

**VICTIMIZED FOR BEING DIFFERENT: YOUNG ADULTS'
RECOLLECTIONS OF BULLYING VICTIMIZATION IN MIDDLE AND HIGH
SCHOOL**

by

CAROLINE IVY MCNICHOLAS

(Under the Direction of Pamela Orpinas)

ABSTRACT

Children with disabilities are bullied up to three times as often as children without disabilities. Children who are victims of bullying can suffer consequences that can last into adulthood including agoraphobia, generalized anxiety disorder, panic disorder, depression, suicidality, and lower academic performance. However, the unique needs of children with disabilities are often not considered in the design and implementation of bullying-prevention interventions. The purpose of this study was to identify internal (emotional competence, self-efficacy) and external (family, peer and school support) factors that protected children with disabilities from bullying victimization.

This retrospective, mixed-methods study was divided into 2 phases. In Phase 1, participants (n=161) were college students registered with the university Disability Resource Center. Each participant completed an electronic survey which queried respondents about bullying victimization, disability status, and protective factors. In Phase 2, ten participants completed one 90-minute in-depth, interpretive interview.

Results from the analysis of Phase 1 results informed the development of the Phase 2 interview guide.

Results indicated that two-thirds of participants in this study experienced bullying victimization, a frequency that is almost three times higher than for students without disabilities. The most frequently reported type of aggression was relational, the second most frequent type was verbal. There were no gender differences in type or frequency of victimization. Participants with disabilities that impacted social skills did not experience significantly different levels of bullying than participants with disabilities that did not impact social skills. Most participants experienced bullying in middle school. Participants who reported higher levels of family, peer, and school support experienced significantly less bullying victimization. Results of the Phase 2 interviews supported the results from Phase 1. Interview respondents reported frequent relational victimization and emphasized the importance of family, peer, and school-related support systems. These support systems aided in coping with and avoiding bullying victimization. Unexpectedly, participants reported disability-related victimization from school staff. Findings from this study are discussed in the context of the existing literature and recommendations made for prevention programs.

INDEX WORDS: bullying, bullying victimization, disability, violence prevention, mixed-methods, qualitative

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DEDICATION

This study is dedicated to my husband Aaron, sister Beth, and brother Frank. You each inspired this work in different ways. Thank you for showing me what it means to be truly resilient.

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ABBREVIATIONS

ADA	Americans with Disabilities Act
ADHD	Attention Deficit Hyperactivity Disorder
CDC	Centers for Disease Control and Prevention
DRC	Disability Resource Center
DSP	Disability Service Provider
EBD	Emotional Behavioral Disorders
IDEA	Individuals with Disabilities Education Act
LD	Learning Disability
UGA	University of Georgia
USG	University System of Georgia

CHAPTER 1

INTRODUCTION

Bullying is a type of aggression that is repeated over time and involves an imbalance of power between the perpetrator and victim. Many different types and definitions of bullying exist in the literature. In 2014, the Centers for Disease Control and Prevention (CDC) put forward their official definition, which specifies that in order for an aggressive act to be classified as bullying, it must meet four criteria (Gladden, Vivolo-Kantor, Hamburger, & Lumpkin, 2014). First, the act must be unwanted, aggressive behavior. Second, there must be an observed or perceived power imbalance between the victim and the perpetrator. Third, the aggression is repeated multiple times or is highly likely to be repeated. Finally, the aggression must inflict harm or distress on the victims. The definition of bullying excludes aggression between siblings. Defining bullying is complex because there are several different types, encompassing a wide range of behaviors: physical, verbal, and relational. Physical bullying includes physical acts such as intentional shoving or fighting; verbal bullying includes threats of violence, intimidation, and abusive remarks; relational bullying occurs through manipulation of or damage to victims' social relationships (Crick & Grotpeter, 1995; Rose, Monda-Amaya, & Espelage, 2011). Physical and verbal bullying are direct forms of bullying (i.e., when the aggressive behavior occurs in the presence of victim such as name-calling, hitting, or

punching) and relational is an indirect form bullying (i.e., aggressive behavior that is not directly communicated to the victim such as spreading rumors).

Approximately 20-26% of school-age children report being victims of bullying (Centers for Disease Control and Prevention, 2011; Schneider, O'Donnell, Stueve, & Coulter, 2012). The frequency of bullying varies greatly by grade level, with the highest frequency during middle school (US Department of Education, 2011). However, epidemiological studies may underestimate the problem due to inconsistent methods of measuring bullying behavior, belief that bullying is a “normal” part of growing up, or victims’ fears of reporting (Orpinas & Horne, 2006).

The negative effects of bullying are well documented. Bullying can have negative effects on virtually all aspects of a victim’s life including poor school performance and detriments to physical and mental health. For example, victims of bullying are more likely to suffer from worse school performance, lower school attachment, and higher absenteeism due to safety concerns (Berthold & Hoover, 2000; Schneider et al., 2012). Arseneault and colleagues (2010) identified bullying as an independent contributor to victims’ mental health problems, rather than a phenomenon that occurs only among children predisposed to mental health problems. Some examples of specific mental health problems associated with bullying are increased psychological distress, depressive symptoms, and suicidal thoughts and attempts compared to same-age peers who were not victims of bullying (Schneider et al., 2012).

For the past several years, the topic of bullying has received increased attention in the academic literature. However, children with disabilities are often not included in this research and may be excluded in the design and implementation of bullying interventions

(Raskauskas & Modell, 2011). Therefore, little is known about how bullying affects these children. Since there are many different types of disabilities, only the most prevalent will be discussed here. These disabilities are termed high incidence disabilities (HID). Students with HID are defined as those who have a diagnoses of the most common disabilities in school-age children (Gage, Lierheimer, & Goran, 2012). Typically, HIDs include learning disabilities (LD), emotional-behavioral disorders (EBD), and attention deficit hyperactivity disorder (ADHD), (Mock, 2008). These categories account for approximately 70% of K-12 students with disabilities (Mock, 2008). However, high functioning autism (formerly known as Asperger syndrome) is also considered to be HID, even though it does not appear in earlier definitions (Gage et al., 2012). For the purposes of this study, LD, EBD, ADHD, & high functioning autism will be included in the definition of HID. One particularly salient characteristic of an HID such as ADHD or high functioning autism is impaired social functioning (Kavale & Forness, 1996), which can increase the risk of bullying victimization and perpetration (Cook, Williams, Guerra, Kim, & Sadek, 2010).

1.1 Present Study

The long-term goal of this study is to identify key factors that protect children with disabilities from bullying victimization. These factors will inform programs and strategies to help educators and parents prevent bullying and help children achieve their full personal and academic potential. The overall purpose of the present study was to identify internal and external factors that protect children and adolescents with disabilities from bullying victimization and examine whether single factors or a combination of factors are most effective. Using a mixed-methods study design, I

surveyed and interviewed young adults with disabilities about their experiences during middle and high school. The specific aims of this study were to:

Specific Aim 1: Describe the recollections that young adults with disabilities have of the frequency and characteristics (physical, verbal, relational, electronic, and disability-related) of bullying victimization during middle and high school by type of disability.

Specific Aim 2: Identify external (family, peer, and school support) and internal (emotional competence, belief-in-self) factors that protected children and adolescents with disabilities from bullying victimization in middle and high school.

Specific Aim 3: Explore and identify themes from the experiences of young adults that protected them from bullying in middle or high school, from the perspective of the participants themselves.

This information will help researchers design studies that address the deficiencies in the literature and plan bullying prevention programs that address the needs of students with disabilities. Asking young adults to remember their past bullying experiences may allow for the discovery of previously unidentified protective factors and new areas of study, which can only be obtained via the insight that comes from retrospection.

CHAPTER 2

LITERATURE REVIEW

This chapter covers several topics relevant to the study of bullying among people with disabilities, and is composed of four sections. The first section provides an overview of the prevalence of disabilities among college students. The second section examines the various types and definitions of bullying and the prevalence of bullying among people with disabilities. The third section discusses the theoretical basis for this study. The fourth section covers techniques for interviewing people with disabilities for research studies.

2.1 Disabilities Among College Students

Recent data from the National Center for Education Statistics indicates that approximately 11% of U.S. students enrolled in a postsecondary institution have a disability (US Department of Education, 2013). Among students diagnosed with disabilities during their K-12 education, approximately one-third enrolled in a postsecondary educational institution (Newman, Wagner, Cameto, Knokey, & Shaver, 2010). Given that less than half of the population of children with disabilities enroll in college, prevalence estimates for disabilities in the college population are lower than for K-12 age children. Results of the National Longitudinal Transition Study-2 indicate that, of students who received disability services in high school, only 40% did so at the postsecondary level (Newman et al., 2010). In a meta-analysis of help-seeking behaviors among postsecondary students, Trammel and Hathaway (2007) found that stigma toward

students with disabilities prevented students from asking for help. Students felt that getting extra accommodations was somehow “cheating” and they did not want to be perceived by peers as lazy. In a study of reasons why college students wait to get disability services, Lightner, Kipps-Vaughan, Schulte, & Trice (2012) found that some students had no knowledge of the change in laws that protect them due to their disability status. Because of those laws, students must pay for testing to document their disability, which research indicates may be a significant barrier to seek help.

When students do seek help from their university office of disability services, it is typically the second semester of the freshman year or in subsequent years of their college experience. One of the most frequently cited reasons for seeking help was academic failure or academic difficulty that prevented other activities (e.g., minimum grade requirements for athletics) (Lightner et al., 2012).

2.2 Bullying Among Students with Disabilities

The literature on school violence discusses many different types of bullying. The definition developed by the CDC states:

Bullying is any unwanted aggressive behavior(s) by another youth or group of youths who are not siblings or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated. Bullying may inflict harm or distress on the targeted youth including physical, psychological, social, or educational harm (Gladden et al., 2014, p. 7).

Bullying includes four types of behavior: physical, verbal, relational, and electronic (Gladden et al., 2014; Orpinas & Horne, 2006). Physical bullying is the intentional use of physical force that has the potential to cause harm. Examples of physical bullying include

hitting, punching, slapping, and damaging property. Verbal bullying is the intentional use of words to cause harm and includes such behaviors as: threatening to cause someone harm, name-calling, teasing, and yelling. Relational bullying is the act of harming someone through damage to his or her personal relationships. Examples of relational bullying include excluding someone from a group, spreading rumors, and withdrawing friendship. Electronic bullying or cyberbullying is a more recent phenomenon, and is a form of aggression perpetrated in an online environment. Examples of electronic bullying include sending verbal threats made via text message, sharing secrets about someone online, posting sexual or unflattering images, and saying mean things while impersonating someone else online (Kowalski, Limber, & Agatston, 2012).

In the United States, the prevalence of bullying among school age children is estimated to be 20% to 28%, depending on the definition of bullying that was used (Centers for Disease Control and Prevention, 2011; Robers, Kemp, & Truman, 2013). The prevalence of bullying among international populations varies widely. Craig et al. (2009) conducted a multi-national study with adolescents (ages 11, 13, and 15) in 40 countries. Prevalence estimates varied from 8% (Sweden) to 45% (Lithuania) for boys and 5% (Sweden) to 36% (Lithuania) for girls. On average, the countries with the lowest prevalence of bullying were from Northern Europe (e.g., Sweden, Finland, and Norway) and the countries with the highest prevalence were from the Baltic region (e.g. Lithuania, Latvia).

Children with disabilities are more frequently the victims of violence than children without disabilities. Jones and colleagues (2012) found that children with mental health disabilities or intellectual impairment were four times more likely than their same

age peers without disabilities to be victims of physical, sexual, or emotional abuse from parents, caregivers, or peers. Children with disabilities are not just at a higher risk of violence victimization, but are at increased risk of victimization from the repeated, long-term violence associated with bullying (Pittet, Berchtold, Akre, Michaud, & Suris, 2010; Swearer, Wang, Maag, Siebecker, & Frerichs, 2012; Turner, Vanderminder, Finkelhor, Hamby, & Shattuck, 2011; Twyman et al., 2010; Van Cleave & Cornell, 2006). However, drawing conclusions from the bullying literature as a whole must be done with caution. For example, statistics of bullying victimization among populations with disabilities varies greatly. Prevalence estimates for bullying victimization in children with disabilities range from less than 7% to 94% (Kaukiainen et al., 2002; Little, 2002).

There are inconsistencies in the literature about whether children with disabilities are at increased risk for bullying victimization when compared to children without disabilities. For example, Kaukiainen and colleagues (2002) studied fifth grade children with learning disabilities in Finland and identified bullies and victims via peer nomination, a common method to study children's social relationships. Researchers provided participants with a definition of bullying, which included physical, verbal, and relational forms of aggression. Students then identified the bullies and the victims in their respective classrooms. Approximately 7% of children reported being the victim of physical, verbal, or relational bullying. However, children with learning disabilities were not victimized significantly more than children without learning disabilities.

In contrast, another study found a much higher rate of victimization for children with Asperger syndrome or nonverbal learning disabilities (Little, 2002). She recruited mothers of children with Asperger syndrome and/or nonverbal learning disabilities from

two online forums. Children were between 4-17 years old, with a mean age of 10 years. Mothers completed questionnaires assessing when and how often their child was the victim of physical, verbal, or relational bullying. Almost all of them (94%) reported that their child had been the victim of some form of bullying during the year prior to the study.

The discrepancy between the results of Kaukiainen et al.(2002) and Little (2002) may be due to several factors. First, the type of disability included (i.e., Asperger syndrome or learning disability (LD)) likely played a major role in the results. Asperger syndrome is a disorder of social interaction, so children with this condition often have profound difficulties reading social cues and understanding the feelings of others (American Psychiatric Association, 2000). These social impairments could make them an easy target for bullying, as their social difficulties may at times make for awkward interactions with peers. Children with LD also have difficulty in social situations, but not at the severity level of a child with Asperger syndrome. Therefore, it is not surprising that the rate of victimization for the Asperger syndrome children was higher. Second, the source of information (i.e., student or parent report) may have led to different results for these two studies. Research indicates that when parents and children are queried about the child's bullying, they tend to report significantly different frequencies (Kumpulainen, Rasanen, & Puura, 2001). Little queried mothers to gather information about their child's victimization. Mothers may report higher levels of victimization for their child with Asperger syndrome than that child would. Due to social impairment, children with Asperger syndrome may not recognize a peer's actions as bullying and could interpret their behavior as playful. Finally, the two studies included different age groups.

Kaukiainen et al. included only fifth grade children (ages 11-12), and the sample in the Little study had an age range of 4-17 years. The age at which bullying is most frequent may be different for children with Asperger syndrome than for children with LD.

The two studies also differed in the method of collecting data (i.e., peer nomination vs. online questionnaire). Little (2002) recruited her sample from an online forum for mothers of children with Asperger syndrome and nonverbal learning disabilities. The author acknowledged that the socioeconomic level of these mothers was much higher than the general population. These educated, high income mothers may be more likely to recognize bullying in their children, leading to higher rates of reporting. In contrast, Kaukiainen's (2002) used peer nominations, which is widely regarded as one of the most reliable and valid methods of assessing children's social relationships (Kane & Lawler, 1978). However, the authors did not address the fact that children with LD may not always recognize a peer's behavior as bullying due to their impaired social skills. Therefore, the prevalence of bullying victimization in children with LD may be underestimated in this study.

The literature on the prevalence of bullying perpetration by students with disabilities also ranges widely from 6% to 32% (Kumpulainen et al., 2001; Van Cleave & Cornell, 2006). Kumpulainen and colleagues interviewed the parents—most frequently the mother—of a representative sample (N=6,017) in Finland. Approximately 18% of participants reported being both victims and perpetrators and smaller portion (6%) reported only perpetration. It is possible that mothers underreported or underestimated the frequency with which their children were involved in perpetrating bullying against other children. This finding builds upon the existing literature which indicates bullying is often

underreported by those in authority positions, such as teachers (de Monchy, Pijl, & Zandberg, 2004).

One subgroup of children with disabilities that is emerging in the violence literature is children with special healthcare needs, which includes children with chronic illness, behavioral problems, and psychiatric conditions. Van Cleave and Cornell (2006) studied U.S. children with special health care needs enrolled in the National Survey of Children's Health, a telephone survey of over 100,000 families with children ages 0-17 years. The telephone survey included two questions about bullying, which ascertained whether the child was involved with bullying either as a victim or perpetrator. Results indicate that approximately 24% of the children with special health care needs reported perpetrating bullying. However, children with special health care needs were more likely than children without a diagnosis to be perpetrators when they had a diagnosis of an emotional or behavioral disorder. The researchers may have over reported the frequency with which children with special health care needs bullied others because no definition of bullying was provided to participants and no examples of behaviors that constitute bullying were given. It is possible that participants classified one-time aggressive acts as bullying.

Several studies found no significant difference in the rate at which children with disabilities were involved in bullying, either as victim or perpetrator, compared to children without the diagnosis (Kaukiainen et al., 2002; Woods & Wolke, 2004). For example, Woods and Wolke studied children with unspecified disabilities in the United Kingdom by interviewing them individually. The participants were queried about incidents of physical, relational, and verbal bullying they have experienced. However, the

authors classified the students by their qualification as Special Educational Needs. Information about the disabilities of each participant was not included, so comparison to other studies is not possible.

As described, estimates for bullying victimization and perpetration among students with disabilities varies widely. These discrepancies are partially due to inconsistent definitions of bullying, types of disabilities included in the samples, and geographic location of the study. For example, both studies that found the lowest prevalence of bullying victimization and perpetration (Kaukiainen et al., 2002; Kumpulainen et al., 2001) were conducted in Scandinavian countries; these countries have the lowest overall prevalence of bullying in the world (Craig et al., 2009). The sample also included a wide variety of disabilities such as LD, developmental disabilities like Autism Spectrum Disorders, psychiatric conditions such as ADHD and depression, and chronic health conditions like diabetes, asthma, and cystic fibrosis. Each of these disabilities has a unique effect on the individual, so each disability likely has a different influence on the child's behavior. Finally, participants reported their own behavior or parents were asked about their child's behavior. Van Cleave and Davis simply asked whether participants had been bullied, whereas Swearer and colleagues provided participants with a definition of each type of bullying and examples of each (Swearer et al., 2012; Van Cleave & Cornell, 2006). At least one study determined that some children had difficulty distinguishing between bullying, teasing, and playful behavior (Mishna, 2004).

2.3 Theoretical Background

The literature examining risk and protective factors for bullying victimization among students with disabilities is scarce. However, several well-established theories have been applied to this area of study and can guide investigators to specific factors for further study. The conceptual model that guides the present study is founded on four theories or models—public health model, ecological model, social-cognitive theory, and covitality—as well as research studies in this area. This section provides a brief overview of these theories and models, followed by a detailed description of the conceptual model.

Public Health Model

In public health, researchers and practitioners often rely on the four-step public health model as a method of reducing unwanted behaviors (Figure 2.1). The first step of the model is to define the problem—in this case, bullying. The second step is to identify risk and protective factors for aggressive behavior. The third step is to design and test an intervention to reduce the problem, and finally, the fourth step is to evaluate the dissemination of effective interventions. This study provides a clear, behavioral definition of the problem behavior and will test the impact of protective factors reducing bullying victimization among students with disabilities.

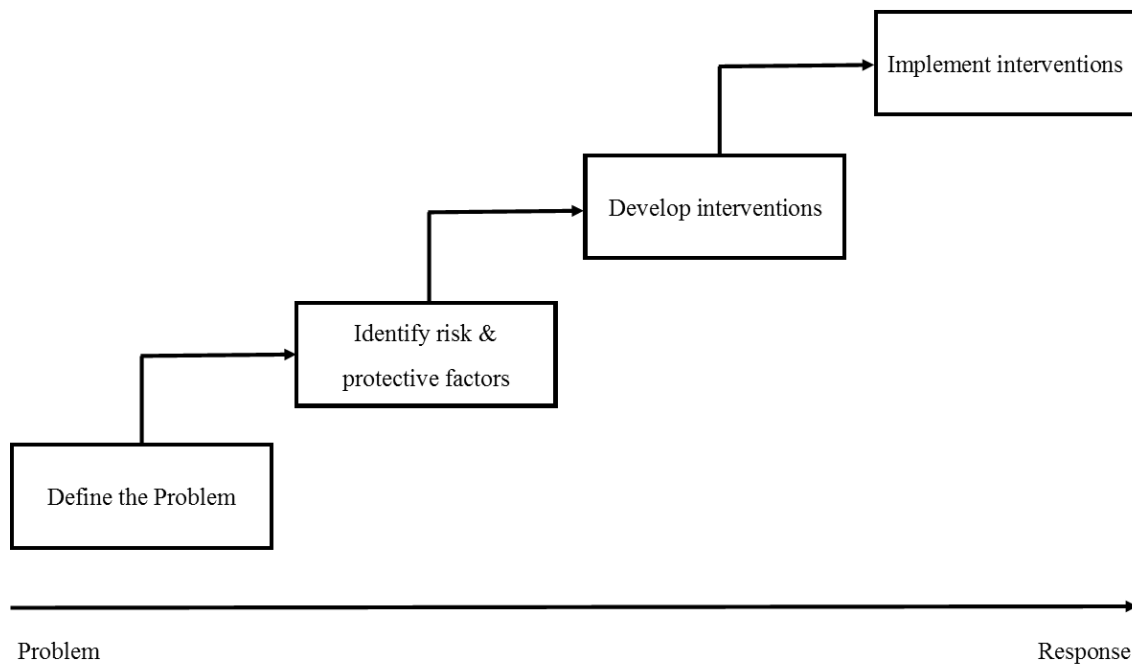


Figure 2.1: The Public Health Model

Ecological Model

Bronfenbrenner's (1979, 1994) comprehensive ecological model shows how multiple factors influence the development of certain behaviors. The ecological model is composed of five subsystems which contain multiple influences on human behavior. Microsystems include influences such as interpersonal relationships; mesosystems include the relationships between different settings (e.g., relationship between home and school environment); the exosystem contains links that take place between two or more settings (e.g., the relationship between a child's home and his or her parent's workplace); macrosystems contain influences at the cultural level (e.g., social norms); and chronosystems refers to the development of human characteristics over time and the environment in which the person lives (e.g., changes in employment over the life span). In the case of bullying, ecological model is useful in identifying risk and protective

factors that may lead to bullying victimization at each level (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

Social Cognitive Theory

Social Cognitive Theory is a broad theory that addresses the plethora of influences on human behavior (Bandura, 1973a, 1986). It has been used to help explain violence (Bandura, 1973c, 2004). One of the main construct of social cognitive, self-efficacy, can be applied to both bullies and their victims (Orpinas & Horne, 2006). For example, for the victim, self-efficacy is the confidence in oneself to diffuse an aggressive situation and handle it appropriately. Another construct of social cognitive theory that can be applied to aggression is reciprocal determinism. Like the social-ecological model, reciprocal determinism addresses multiple influences on behavior. Specifically, that the environment, cognitive characteristics, and individual behaviors are continuously interacting with one another. According to social cognitive, this interaction has important implications for bullying prevention because reducing bullying behavior involves the modification of behavior at multiple levels: school, home, and the child.

Covitality

A theoretical perspective that is emerging from the literature is based on several components of social cognitive theory, such as self-efficacy, and the ecological model, in terms of the multiple levels of influence. The construct is termed *covitality* and refers to the “synergistic effect of multiple positive mental health resulting from the interplay among multiple positive-psychological building blocks” (Furlong, You, Renshaw, Smith, & O'Malley, 2013, p. 3). Covitality could be understood as a protective factor index, the opposite of a risk factor index (Furlong et al., 2013; Masten, 2014). That is, covitality is

the combined effect of positive mental health indicators or protective factors (e.g., family support, self-efficacy), whereas a risk factor index refers to the combined effect of multiple risk factors or diseases (i.e., dysfunctional family, poor social skills). Early research indicated that combining these positive mental health indicators had a strong positive association with measures of resilience and a negative association with depression and anxiety than any of the individual constructs alone (Hinshaw, 2013). Furlong and colleagues (2013) developed questionnaire measuring covitality, named Social and Emotional Health Survey. They found evidence for the validity and utility of covitality to conceptualize adolescent health and well-being. The questionnaire is composed of 12 constructs that measure different aspects of well-being, including self-efficacy, self-awareness, persistence, school support, family coherence, peer support, emotional regulation, empathy, behavioral self-control, gratitude, zest, and optimism. Several of these constructs will be used in the present study.

Conceptual Model

Figure 2.2 displays the theoretical model that guides this study. The *External Protective Factors* box contains three protective factors: caring and helpful nature of family, peer, and school relationship. Supportive relationships with family, peers, and school staff have been linked to decreased bullying victimization among children without disabilities (Orpinas & Horne, 2006). The *Internal Protective Factors* box includes emotional regulation (effectively expressing and managing one's emotions), empathy (perceiving and sharing the emotions of others), behavioral self-control (effectively expressing and managing one's emotions), and self-efficacy (one's confidence in their ability to meet the demands of their environment) (Furlong et al., 2013). All of these

factors have been found to reduce the frequency of bullying victimization (Burke, Pardini, & Loeher, 2008; Hinshaw, 2005; Holt, Kantor, & Finkelhor, 2009; Orpinas & Horne, 2006).

The concepts included in the internal and external protective factors boxes are not only related to bullying victimization, they are related to one another as well. For example, studies indicate that children with better empathy, emotional regulation, behavioral self-control have more relationships and thus more opportunities to further develop those skills (Furlong et al., 2013; Hinshaw, 2005; Masten, 2014).

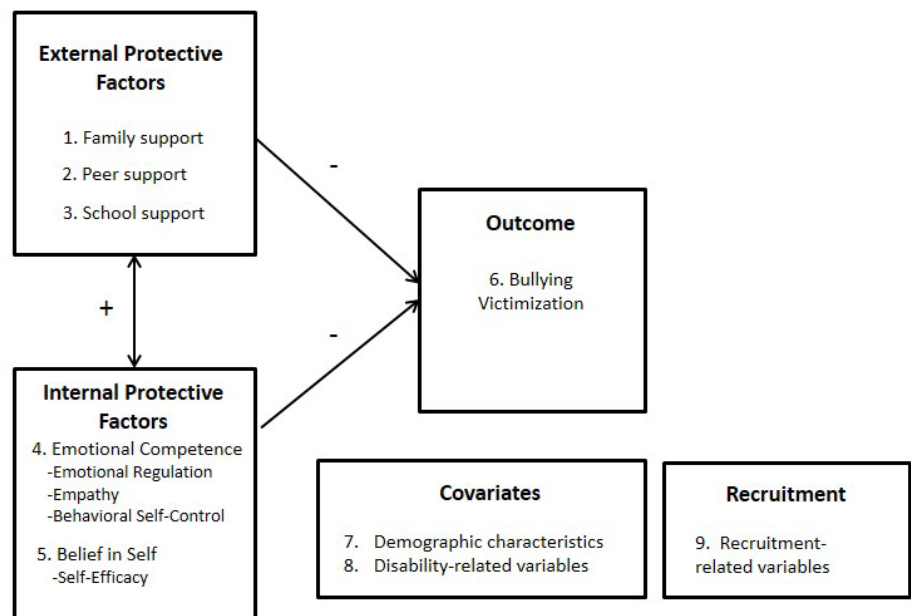


Figure 2.2: Conceptual Model of "Victimized for Being Different"

1. Family support - Families play an important role in the life and development of children. Having a positive, supportive relationship with parents increases the chance that a child will approach his or her parents during times of trouble and has been shown to reduce children's associations with delinquent peers (Barnes & Farrell, 1992; Novilla,

Barnes, De La Cruz, Williams, & Rogers, 2006). According to the social ecological theory (Bronfenbrenner, 1979) family life must be considered in the modification of behaviors because family life interacts with factors at multiple levels (e.g., community, societal, and peer) that combine to produce a sense of well-being. This may be especially useful in thinking about risk and protective factors that can lead to bullying victimization (Krug et al., 2002). Dysfunctional family life may be a risk factor for bullying (Vissing & Straus, 1991). Insecure attachment to the primary caregiver has also been identified as a risk factor for relational aggression (Michiels, Grietens, Onghena, & Kuppens, 2008).

Social Cognitive Theory can also help explain the importance of family support in the case of bullying victimization (Bandura, 1986). A central tenet of this theory is that individuals imitate the behaviors of those they admire (i.e., modeling). When a child is raised in an aggressive home and repeatedly witnesses aggressive behaviors, that child is more likely to become involved in aggressive situations (as either victim or perpetrator).

2. Peer Support - As children mature and enter adolescence, they spend less time with their families and more time with peers (B. B. Brown & Larson, 2009). Therefore, these peer relationships become increasingly important during middle and high school. Acceptance by a peer group is one of the most salient protective factors against bullying perpetration and victimization (Odom et al., 2006). In a recent qualitative interview study of 10 children with disabilities, investigators found that peer support decreased the risk of bullying involvement and also helped children cope with victimization (Bourke & Burgman, 2010). Having a disability that was less likely to affect social problem solving and emotional regulation was a protective factor against bullying perpetration and victimization (Odom et al.). However, children with disabilities are generally less

accepted by their peers (Coolidge, DenBoer, & Segal, 2004; de Monchy et al., 2004; Gans, Kenny, & Ghany, 2003; Kavale & Forness, 1996; Mishna & Alaggia, 2005; Odom et al., 2006; Olin & Jansson, 2009; Tani et al., 2012; van Dyck, Kogan, McPherson, Weissman, & Newacheck, 2004; Wiley, Siperstein, Forness, & Brigham, 2010). Therefore, interventions that target social skills and development of peer relationships may decrease bullying involvement for children with disabilities.

3. School Support - Many of children's social interactions take place in school. Many of those interactions are with school staff such as teachers, principals, and school counselors. Given the large amount of time that children spend at school each day, bullying researchers must consider sources of support within the school environment that may enhance children's protection against bullying. Schools that have a positive social climate have been shown to be especially effective at reducing bullying (Orpinas & Horne, 2006). A positive school climate is an environment in which students, teachers, and administrators mutually respect and support one another. This respect and support between school staff and students has also been identified as a protective factor for bullying victimization (Burke et al., 2008). For example, Konishi and colleagues studied Canadian adolescents and found that students with greater feelings of student-teacher connectedness had lower levels of bullying involvement.

4. Emotional Competence - Another interpersonal protective factor for bullying victimization is a set of skills used to develop and maintain interpersonal relationships (Orpinas & Horne, 2006). Emotional competence consists of traits such as empathy (the ability to consider, perceive, and appreciate another's perspective), emotional regulation (expressing positive emotions and managing negative emotions), and behavioral self-

control (expressing and managing behavior) (Furlong et al., 2013). Furlong and colleagues describe emotional competence as an essential feature of an adolescent's social and emotional health, and an important component of civility. The concepts of emotional competence can be applied to bullying. For example, empathy refers to a student's ability to recognize bullying situations and the realization that those behaviors are unacceptable. Emotional regulation and behavioral self-control are critical concepts in bullying prevention, as negative, unregulated emotions often precede acts of violence. These three factors are also components of larger set of social skills, which are the skills needed to develop and maintain successful relationships with others. Kaukianinen and colleagues (2002) found that low social skills were related to bullying behavior in children with disabilities. The authors identified two groups of bullies in their study: one with high social skills and one with low social skills. Many bullying interventions target children with low social skills (Obradovic, Shaffer, & Masten, 2012; Orpinas & Horne, 2006), but these interventions may not be reaching all bullies.

5. Self-Efficacy - One of the main constructs of social cognitive theory, self-efficacy, can be applied to both bullies and their victims (Orpinas & Horne, 2006). For example, for the victim, self-efficacy is the confidence in oneself to diffuse an aggressive situation and handle it appropriately. Self-efficacy is the construct of social cognitive theory that most accurately predicts behavior, and it is most commonly identified in research (Fuemmeler et al., 2006). In their Social and Emotional Health Survey for adolescents, Furlong and colleagues (2013) define general self-efficacy as one's ability to act effectively to meet environmental demands (Brody et al., 2012).

6. Bullying - The bullying literature typically identifies three distinct types of bullying: physical, verbal, and relational (Orpinas & Horne, 2006). These three types of bullying will be measured in the present study. Physical bullying includes behaviors such as hitting, punching, and shoving. Verbal bullying includes making threats, saying mean things to someone, and being threatened. Relational bullying includes being excluded from a social group or spreading rumors.

Children and adolescents may encounter bullying behaviors typically seen offline, when they use social media and other forms of electronic communication (Sticca & Perren, 2013). When a child or adolescent is victimized online, this behavior is termed cyberaggression. When cyberaggression occurs repeatedly and over an extended period of time, it is called cyberbullying (Kowalski et al., 2012). Cyberbullying can also include behaviors such as cyberstalking (e.g., frequently posting and visiting a victim's social networking profile page, instant messaging the victim multiple times a day), ostracism/exclusion (e.g., making plans via a social network site when a victim is watching), and sexting (e.g., sending sexually inappropriate pictures or videos to a victim).

Research indicates that among children with disabilities, bullying can be directly related to the child's disability. Bourke and Burgman (2010) interviewed Australian children with disabilities and found that they were bullied because of the equipment they used (e.g., wheelchairs) or because they looked physically different from their peers. Children also reported experiencing relational and verbal aggression from peers, although it was not clear whether this behavior was linked directly to the disability.

Covariates

This study will examine whether the impact of the protective factors on bullying victimization are moderated by two sets of covariates, demographic characteristics and disability-related variables.

Demographic characteristics. Among all students, with and without disabilities, gender and age are associated with bullying. Boys were more likely to perpetrate bullying and be bully-victims (Glumbic & Zunic-Pavlovic, 2010; Kumpulainen et al., 2001; Waseem, Arshad, Leber, Perales, & Jara, 2012). Another factor that puts children with disabilities at risk for bullying is age. All children experience more bullying in Grades 5 to 9 than at other ages (Turner et al., 2011; Van Cleave & Cornell, 2006; Waseem et al., 2012), although bullying may begin as early as age 3 (Son, Parish, & Peterson, 2012). Son and colleagues did a longitudinal study of children ages 3-5 and found that up to 21% experienced relational bullying at age 3. The prevalence of bullying increased throughout the course of the study. Longitudinal studies like this one are rare, and more research is needed to determine whether the same children experience bullying throughout childhood. In addition to gender and age, this study includes other demographic variables that will be used to characterize the sample: race, ethnicity, school type (e.g., public, private), geography (e.g., urban, rural location), and employment status.

Disability-related variables. In this study, I measured disability type and age at diagnosis. One of the main risk factors for bullying among people with disabilities is type of disability. Having a learning disability or psychiatric disorder is associated with an increased risk of victimization (Coolidge et al., 2004; Farmer et al., 2012; Kumpulainen

et al., 2001; Swearer et al., 2012; Turner et al., 2011; Van Cleave & Cornell, 2006) and perpetration (Kaukiainen et al., 2002; Kumpulainen et al., 2001; Swearer et al., 2012; Vaughn et al., 2010; Waseem et al., 2012). Children and adolescents with ADHD had some of the highest rates of bullying victimization and perpetration (Kumpulainen et al., 2001; K. Lee, 2012; Turner et al., 2011). However, results were not consistent across studies. Turner and colleagues, in their study of over 4000 children, found that ADHD increased the risk of victimization or of being a bully-victim, whereas Kumpulainen et al. found that ADHD only increased the risk of being a perpetrator. Lee, in her review of bullying in children with ADHD, recognized the behavioral traits that overlap between bullies, victims, and children with ADHD. For example, aggression, impulse control, and defiance are typical traits of children with ADHD and children who act as bullies, while difficulties with attention, low self-esteem, and few friendships characterize both children with ADHD and bullying victims.

2.4 Interviewing People with Disabilities

When a new issue, situation, or concept is discovered in the scientific community, researchers often use inductive, qualitative approaches to understand a topic for which there is little to no data (Belgrave, Zablotsky, & Guadagno, 2002). Interviewing is one of the most common and effective ways to find a large, detailed body of information about an issue (Roulston, 2010). An advantage to using interviews for an emerging area of research (e.g., bullying among children and adolescents with disabilities) is that it offers a flexibility that is not usually available in quantitative research. That is, researchers can modify questions based on the answers from participants (DeMarrais, 2004). This

flexibility allows for the exploration of new ideas and concepts that emerge during the interview.

Interview research offers benefits for researchers, and participants can benefit from the experience as well. Hutchinson and colleagues (2001) listed seven potential benefits for participants that engage in qualitative interviews. The authors state that qualitative interviews can 1) promote healing from past negative experiences, 2) serve as catharsis, 3) contribute to a sense of purpose, 4) increase self-awareness, 5) increase feelings of empowerment, 6) give a voice to the voiceless or disenfranchised, and 7) provide self-acknowledgement and validation. In addition, interviewees may also benefit from developing a relationship with the researcher (DeMarrais, 2004).

No two interviews are exactly alike, which means the process of preparing for each interview will be slightly different. However, all researchers must follow a similar set of steps to complete the interview process. There are three phases to interviewing: preparing for the interview (i.e., the “getting ready” phase), conducting the actual interview, and bringing the interview to a close (DeMarrais, 2004). Each of these phases will be described in detail, and unique aspects of interviewing a person with a disability as it pertains to each phase will be discussed.

Preparation

The preparation phase is often the lengthiest phase of the interview process. This phase usually starts with conducting background research on the population of interest (Roulston, 2010). The background research is especially important when interviewing a person with a disability. First and foremost, the type of disability may influence how and even if the potential participant can complete the interview. Interviewing people with

certain disabilities that affect cognitive functioning may necessitate that a third party (e.g., guardian, case worker, relative) be present in the interview. For example, people with intellectual impairment, autism spectrum disorders, traumatic brain injury, and severe mental illness may all have individuals that care for them on a daily basis and could provide valuable information about that person's day-to-day life. Furthermore, the third party may need to transport the individual to and from the interview if the interviewee cannot drive. Considering whether the interviewee needs specific accommodations (e.g., a wheelchair ramp, fragrance free room, specific lighting) may influence the location that is chosen for the interview as well. Finally, the researcher must consider what benefits the participant will receive for participating in the study. deMarrais (2004) suggests that one potential benefit to interviewees is the increased knowledge and satisfaction they may gain from telling their story, the formation of a new relationship between researcher and participant, or an incentive (e.g., gift card) provided by the researcher. Independent of the benefit, the researcher should ensure that the participant has a positive experience.

The interviewer also needs to be sensitive to the culture that exists within the disability community, including unique subcultures for different types of disabilities (Peters, 2000). For example, people with physical limitations may share the common experience of trying to find accessible housing, making sure that the restaurant they want to try is handicap accessible, buying specific types of cars that accommodate a wheelchair, and advocating for disability rights. These experiences create a common bond that unites people with disabilities. Interviewers who are not a part of this culture (i.e., do not have the same disability as the interviewee) may have more difficulty building a rapport.

After doing background research on the population of interest, the next step is getting consent to conduct the research from an institutional review board. Historically, the rights of certain groups have been violated for the purpose of conducting research. One of the most severe examples of this exploitation is the medical experimentation, sterilization, and euthanasia carried out by the Nazis during World War II (MacInnes, 1999). The Nuremberg Code of Ethical Practice of 1949 was established to protect the rights of research participants by requiring that they give voluntary consent. The United States takes further precautions against violating the rights of vulnerable populations by designating people with disabilities as a special class of research participants, along with children, pregnant woman, and terminally ill patients (U.S. Department of Health and Human Services, 1993). Protocols involving these populations will likely face increased scrutiny, as the principal investigator must demonstrate that the research is directly related to the disability. The researcher must also make the case that excluding this population from research altogether outweighs the risk from participating (Calvey, 2012).

Researchers must not only get approval from their institutional review board, they must also get approval from possible “gatekeepers” (Roulston, 2010). A gatekeeper is a person that may be in charge of, or hold some authority over, the target population. One example of a gatekeeper is a school principal and the board of education for that school district. To collect data at school, researchers must usually get written approval from school administrators, including the principal and the board of education. They are called gatekeepers because, if the population of interest is school age children, researchers cannot access them without approval from these school officials. Several factors may

influence whether a gatekeeper will allow a researcher to “enter” and collect data (Wanat, 2008). First, gatekeepers will often consider public relations aspects of the research. For example, if there is a possibility of negative findings, the gatekeeper will likely want to know whether those findings could be exposed to individuals beyond the research team. Second, power issues could be influential, especially when participants feel that an authority figure is requiring them to participate in the research and, as a result, feel resentment. Finally, accountability is important to ensure participants that there is no unstated motive for doing the study.

Among people with disabilities, the gatekeeper may be a family member, caseworker, or other person that cares for the individual. This person sometimes serves as an advocate for the individual with a disability, and may want to “investigate” the researcher and the motives for the research study before allowing their loved one to participate (Tasse, Schalock, Thompson, & Wehmeyer, 2005). Researchers must take special caution when a third party is involved in the consent process, so the individual with a disability does not feel unduly coerced into participating in the study (Calvey, 2012).

The next step in the preparation process is recruiting the research participants themselves. Recruiting can involve several methods such as personal networks, advertisements, and listservs (Roulston, 2010). Using personal networks means recruiting one’s sample through family, friends, acquaintances, and mutual connections. A common way to access personal networks is to identify one member of a group that fits the selection criteria, and ask that person to refer to other eligible individuals (DeMarrais, 2004). If the researcher does not have any personal connections to the population of

interest, Roulston (2010) suggests using indirect methods of recruitment such as mailing lists, listservs, or websites. Although response rates for these recruitment methods are typically low (Lohse, 2013), having a gatekeeper willing to promote the study to members may increase the chances of recruitment success. Another approach to recruitment is the distribution of advertisements such as fliers, which is typically used on college campuses and in large institutions where many people may see a bulletin board.

People with disabilities are a heterogeneous group, which can make recruitment difficult. There is a high degree of comorbidity with disabilities (Mock, 2008). Depending on the disability and phenomenon under investigation, this heterogeneity may be an asset or a confounding factor in sampling. Interviewees may be hesitant to be forthcoming in an interview or to participate at all, if they do not trust that their information is secure. Assurance that data will be confidential may aide in recruitment of individuals only when there is no way of linking specific records with specific persons (not even by participant numbers or codes) or no records or participation-such as signed consent forms (although verbal informed consent is obtained)-can one protect against the risk of a break in confidentiality (Lipson, 1994).

Once the participants have been selected, the researchers must select a time, date and location to conduct the interview. These interviews are scheduled at a mutually available time for the interviewer and interviewee. The location is especially important in the case of sensitive interview topics. Overhearing audiences could violate the privacy of the interviewee. This potential for overhearing is likely to occur in coffee shops, restaurants, and other public venues. Public places may make recording the interviews difficult due to background noise. In considering the needs of individuals with

disabilities, location may be a deciding factor in whether they are able to participate in the study. For example, an individual with mobility limitations may have difficulty arranging transportation to an interview. In these cases, the willingness of the researcher to travel to the participant's home may be the only way to conduct the interview. In addition, certain elements of the interview room itself need to be considered in relation to the target population. Some individuals with conditions such as autism, severe allergies, or other sensitivities may have severe reactions to fragrances and certain fabrics on furniture. These potential problems underscore the importance of background research and talking to participants to minimize any potential discomfort.

The Interview

Most of the literature on interviewing people with disabilities suggests using an approach that is similar to interviewing someone about a sensitive topic (Belgrave et al., 2002; Corbin & Morse, 2003; R. M. Lee & Renzetti, 1990; Tasse et al., 2005). Some topics have a higher probability of arousing painful memories and powerful emotions than others. Such topics include those that delve deeply into the personal life of the interviewee, those that explore deviant or illegal activities (e.g., violence), religious questions, and questions involving power and control (R. M. Lee & Renzetti, 1990). The stigma associated with having a disability has the potential to cause stress for an interviewee (Pescosolido, Talt, Medina, Martin, & Long, 2013). Sensitive topics should not be avoided; however, the interviewer must assure the interviewee that the interview can be stopped at any time for any reason.

The nature of the disability under investigation may dictate what questions are asked and how those questions are asked. deMarrais (2004) suggests that for most

interviews, the interviewer should ask questions that are short and clear and that describe specific events and experiences in detail. Questions of these types will result in fuller narratives and higher quality data. These principles generally apply to interviewing a participant with a disability, but disability-specific issues must be taken into account when designing questions. For example, interviewees with post-traumatic stress disorder may become extremely agitated and further traumatized by certain questions, so determining topics to be avoided is critical to the establishment of rapport and the success of the interview. Individuals with dyslexia and other learning disabilities may not process verbal information at the same speed as someone without this condition and may therefore need more time to answer questions (Fletcher, Lyon, Fuchs, & Barnes, 2006; Mock, 2008). In addition, memory impairment is a defining feature of some disabilities (e.g., bipolar disorder, dementia, traumatic brain injury) so the interviewer may need to repeat some questions (American Psychiatric Association, 2000). Some authors have argued that the cognitive and linguistic demands of interviewing prevent the full involvement of people with certain disabilities (e.g., learning disabilities, autism, cognitive impairment) but it is important that they still contribute their views (Kiernan, 1999).

The type of questions included in an interview may also depend on whether additional people are in the room during the interview. Some researchers suggest that two or more respondents who know the person well should be present during the interview, and that participants should be encouraged to invite trusted friends or family members to participate (Tasse et al., 2005). Interviewing can be very demanding for participants, both emotionally and cognitively. Individuals need to have the self-esteem to believe that their

views are valid and important. Participants who are shy or socially unskilled may need the emotional support of a familiar and valued person, those who would also contribute if needed. Others may benefit from being in a group in which there is a role model who demonstrates how to respond, thereby reducing their feelings of anxiety and risk.

Interviewing can be emotionally taxing for both interviewer and interviewee. For this reason, participants (and researchers) may also need a few minutes to “come out” of their deep emergence in their story. This is especially important if the interview is about a sensitive topic such as bullying, violence, or any kind of victimization (Corbin & Morse, 2003). deMarrais (2004) suggests that at the end of the interview, the conversation shifts toward more light-hearted, benign topics for a few minutes. At this point, the researcher must decide whether to offer the participant (or proxy) a chance to view the transcript at a later point in time. Depending on the type of disability, this may prove very useful for the researcher. A participant who has a speech disorder may be difficult to understand on the tape recorder, and having his or her input on whether the transcript is accurate adds another layer of reliability to the data. This collaboration will ensure reciprocity between the researcher and participant, each having some input on the generation of data.

CHAPTER 3

METHODS

This chapter describes the methodology of this study. The chapter is divided into five sections. Section one describes the design, research questions and hypotheses. Section two describes the study participants, including inclusion and exclusion criteria. Section three describes the quantitative and qualitative measures that will be used in this study. Section four details the study procedures. Finally, section five describes the data analysis and researcher subjectivities.

3.1 Study Design, Research Questions and Hypotheses

This study was conducted in two sequential phases: quantitative and qualitative. I chose this mixed-methods design because of the emerging nature of the research literature on protective factors for bullying among children and adolescents with disabilities. Mixed methods research also has the advantage of strong design that comes from triangulating multiple data sources (Greene, 2006). Phase 1 consisted of a survey that queries young adults retrospectively about their experiences with bullying victimization during middle and high school and about various protective factors at the individual, family, peers, and school levels of the ecological model. The survey measured each construct of the conceptual model. Two qualitative, open-ended questions were included in the survey as well. Phase 2 was qualitative and was informed by the results of Phase 1. This Phase consisted of 1-hour interpretive, phenomenological interviews with university students who had a diagnosed disability. The objectives of these interviews was to understand from the experience bullying victimization from the participants

themselves, as well as the factors that protected them and that increased their risk. These interviews may help identify new areas of future inquiry.

I chose an in-depth, interpretive framework because bullying among students with disabilities is an evolving area of study. In-depth interpretive research is an ideal approach to explore emerging topics because it allows researchers to study a small group of people for an extensive and prolonged period of time (Moustakas, 1994). This level of access allows the researcher to identify new themes, patterns, and relationships of meaning that have not yet been identified in the literature. Interpretive interviews can reveal multiple realities, and thus future areas of inquiry (Luthar, Cicchetti, & Becker, 2000).

Figure 3.1 integrates the conceptual model for this study with the hypotheses. This retrospective, mixed-methods study was guided by the following objectives and hypotheses:

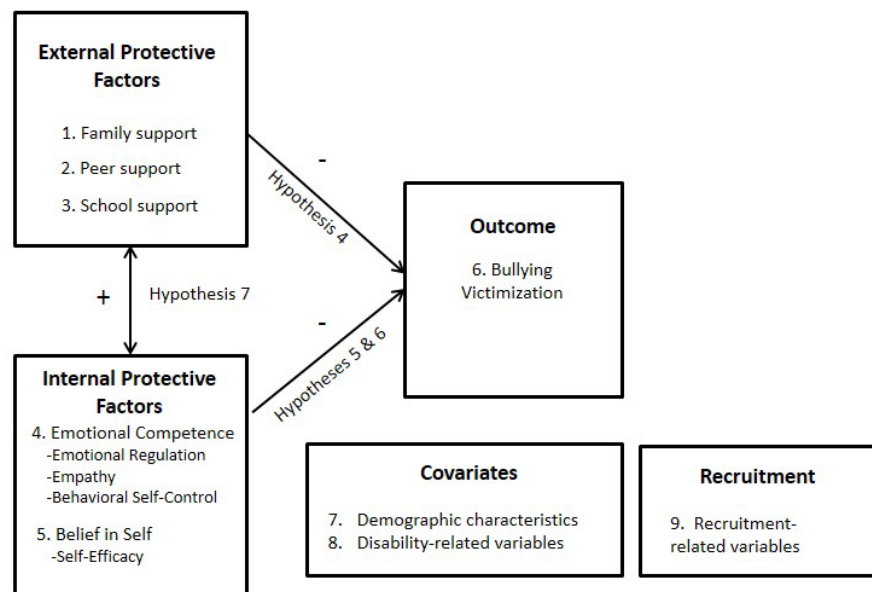


Figure 3.1: Conceptual Model with Hypotheses

Objective 1 – Prevalence And Type Of Bullying:

Describe the recollections that young adults with disabilities have of the frequency and characteristics (physical, verbal, relational, electronic, and disability-related) of bullying victimization during middle and high school by type of disability.

Hypothesis 1: At least 20% of study participants will report physical, verbal, relational, or electronic bullying victimization.

The literature on bullying victimization among children without disabilities indicates that the prevalence is approximately 20% (Blake, Lund, Zhou, Kwok, & Benz, 2012; Centers for Disease Control and Prevention, 2011).

Hypothesis 1a: Females and males will report significantly different types of victimization.

Females are more likely to be victims of relational aggression, while males are more likely to be victims of physical aggression (Orpinas, McNicholas, & Nahapetyan, 2014; Woods & Wolke, 2004)

Hypothesis 2: The prevalence of bullying among participants in this study will be higher in middle school than high school.

Among children without disabilities, research indicates that the prevalence of bullying victimization is higher in middle school than in high school (Craig et al., 2009).

Hypothesis 3: Participants with disabilities that impact social skills (i.e., LD, ADHD, high functioning autism, and EBD) will report more victimization than participants with other disabilities.

Research indicates that children with a diagnosis of LD, ADHD, high functioning

autism, and EBD experience bullying victimization more frequently than children with other types of disabilities (Beauchaine, Klein, Erickson, & Norris, 2013; Estell et al., 2009; Kaukiainen et al., 2002; Turner et al., 2011).

Objective 2 – Protective Factors

Identify external (family, peer, and school support) and internal (emotional competence, belief-in-self) factors that protected children and adolescents with disabilities from bullying victimization in middle and high school.

Hypothesis 4: Participants who report stronger family, peer, and school support will report significantly less bullying victimization than students with weaker external support.

Research on children without disabilities indicates that family, peer, and school support decrease bullying victimization (Analitis et al., 2009; Orpinas & Horne, 2006) and qualitative interviews indicate that this is the case for children with disabilities (Bourke & Burgman, 2010).

Hypothesis 5: Participants who report more emotional competence—emotional regulation, empathy, and behavioral self-control—will report less bullying victimization than participants with lower levels of emotional competence.

These traits have been linked with peer acceptance, which decreases the risk of bullying victimization (Hinshaw, 2005)

Hypothesis 6: Participants who report higher self-efficacy will report less bullying victimization than participants with lower self-efficacy.

A recent study indicated that bullying victimization among children without disabilities was negatively correlated with self-efficacy (Hinshaw, 2005).

Hypothesis 7: Family, peer, and school support will be associated with stronger emotional competence and belief in self.

Children who receive support from family, peers, and school staff have more relationships than rejected (i.e., unsupported) children, and thus have more opportunities to display empathy and emotional competence (Furlong et al., 2013; Hinshaw, 2005; Masten, 2014)

Hypothesis 8: Participants who have a higher protective factor index (i.e., combination of internal and external protective factors) will report less bullying victimization than participants with a lower protective factor index.

Furlong and colleagues (2013) reported that covitality (i.e., more protective factors) was a better predictor of adolescent well-being and quality of life than any of the protective factors individually. Adolescents' covitality scores were also associated with academic achievement, substance use, depressive symptoms, and perceptions of school safety.

Objective 3 – Contextual Inquiry

Explore and identify themes from the experiences of young adults that protected them from bullying in middle or high school, from the perspective of the participants themselves.

1. How do participants describe the bullying they experienced in childhood?
2. How did participants perceive the experience and results of bullying disclosure?
3. How did participants experience protection from bullying? [and what put them at higher risk]

3.2 Participants

Phase 1-Survey

The sample consisted of 161 participants. There were 15 participants who skipped survey questions. Therefore, the final sample size is 146 participants. Demographic characteristics are listed in Table 3.1. The target population for the quantitative portion of this study was young adults 18 years of age or older who had a diagnosed disability. History of bullying victimization was not required to participate in the study. Participants were recruited from the University of Georgia (UGA) Disability Resource Center (DRC). The University of Georgia is a public, coeducational university that was founded in 1785 and is the first state-chartered university in America. The total number of students in 2013 was approximately 34,000. The DRC at UGA serves approximately 1500 students.

Table 3.1: Phase 1 Participant Demographics (n=146)

	N	%
Gender		
Male	29	19.9
Female	114	78.1
Transgender	3	2.1
Race		
White	118	62.4
Black	6	3.2
Asian Indian	4	2.1
Other	7	3.7
Current Student Status		
Full-time	131	89.7
Part-time	11	7.5
Not currently enrolled	4	2.7
Current Employment Status		
Full-time	5	3.4
Part-time	59	40.4
Not employed	82	56.2
Mean Age	22.4 years	

Table 3.2 is an overview of the disability characteristics of the Phase 1 sample. The most prevalent disability categories were Psychological Disorder, ADHD, and LD.

Table 3.2 Sample Disability Characteristics

USG Disability Documentation Category	Study Sample n	% of Study Sample %	% in General DRC Population %	Age of Diagnosis Mean (SD)
Psychological Disorder	63	45	25	17.1 (7.9)
Attention Deficit Hyperactivity Disorder	61	42	44	15.4 (8.5)
Learning Disability	45	32	20	14.1 (6.9)
Systemic Disorder	43	31	12	12.4 (5.8)
Mobility Disorder	27	19	6	14.4 (11.7)
Other	21	16	N/A	12.9 (7.3)
Sensory Processing Disorder	21	16	N/A	11.5 (13.8)
Acquired Brain Injury	18	13	9	13.8 (7.8)
Pervasive Developmental Disorder	13	9	2	12.2 (10.6)
Mean Number of Disability Diagnoses	2.15 (1.5)			

Note: Information not available (N/A)

Phase 2-Interview

There were two men and seven women ($n=10$) who participated in the interview portion of this study. Participants were recruited from the Phase 1 sample. At the end of the Phase 1 survey, participants were asked whether they would be willing to be contacted by researchers for an interview study. There were 53 participants who indicated

that they were interested in participating in the interview. All 53 participants were contacted via email. Of those, 16 participants replied, and ultimately 10 were scheduled for interviews. There were 6 participants who could not participate due to scheduling conflicts. Interviewees must have had a disability that was diagnosed by a health-care provider (e.g., psychiatrist, psychologist, physician, speech pathologist). As in Phase 1, interviewees did not need to have a history of bullying victimization to participate. Table 3.2 lists demographic characteristics of the Phase 2 sample.

Table 3.3 Phase 2 Participant Demographics (n=10)

Pseudonym	Gender	Age	Student Status	Disability
Ashley	F	21	Undergraduate	Bipolar Disorder, ADHD
Buddy	M	25	Graduate	LD, ADHD
Sarah	F	18	Undergraduate	ADHD
Jason	M	32	Graduate	ADHD
Tyra	F	19	Undergraduate	Generalized Anxiety Disorder
Anna	F	20	Undergraduate	Type 1 Diabetes
Becca	F	20	Undergraduate	Type 1 Diabetes
Jamie	F	18	Undergraduate	Brain Tumor
Lindsay	F	23	Graduate	Chronic Regional Pain Syndrome, LD
Krystal	F	18	Undergraduate	Congenital Muscular Dystrophy

3.3 Measures

Phase 1: Survey

The survey for Phase 1 contained 49-item items that queried participants about protective factors, bullying victimization, and demographic information (See Appendix A).

Family, Peer, and School Support: Perception of family support (3 items, e.g., “My family members really help and support one another”), peer support (3 items, e.g., “I

had a friend my age who really cared about me”), and school support (3 items, e.g., “In my high school, there was a teacher or other adult who listened to me when I have something to say”) was measured using three subscales of the Social and Emotional Health Survey (Furlong et al., 2013). Response categories are *not at all true, a little true, pretty much true, and very much true*. Internal consistency for the entire questionnaire of 32 items was .92. Three additional questions (1 for family, 1 for peer, and 1 for school), developed for this survey, queried participants about support in relation to their disability. For example, “my parents or guardians had a good understanding of my disability.” The internal consistency of this scale for the current sample, including the added question about disability, was .85. Chronbach alpha testing indicated that the internal consistency of the scale was not significantly altered by the disability question (e.g., .86 vs .85).

Social-Emotional Competence: Social-emotional competence was measured using three subscales of the Social and Emotional Health Survey (Furlong et al., 2013). The subscales are emotional regulation (3 items, e.g., I accept responsibility for my actions), empathy (3 items, e.g., I try to understand how other people feel and think), and behavioral self-control (3 items, e.g., I think before I act). The prompt directs participants to select the answer that best describes the truth of the statement: *not at all true, a little true, pretty much true, and very much true*. The internal consistency of this 9-item scale for the current sample was .82.

Belief in Self: Participants’ belief-in-self (i.e., their self-efficacy) was measured using one subscale of the Social and Emotional Health Survey (Furlong et al., 2013). This subscale was composed of six items measuring general self-efficacy, defined as one’s ability to act effectively to meet environmental demands (e.g., I can do most things if I

try). The prompt directed participants to select the answer that best describes the truth of the statement: *not at all true, a little true, pretty much true, and very much true*. The internal consistency of this 6-item scale for the current sample was 90.

Bullying Victimization: Bullying victimization was measured using questions adapted from the Retrospective Bullying Questionnaire (Schafer et al., 2004). The Retrospective Bullying Victimization Scale (6 items; $\alpha=.87$) measures the frequency of being the target of physical (being hit, punched, or shoved; stolen from), verbal (being called bad names, being threatened), and relational aggression (having lies or rumors told, being deliberately excluded). Questions were slightly adapted for an American population. For example, “having lies or nasty rumors told about you behind your back” was changed to “having lies or bad rumors told about you behind your back.” One question was added to capture electronic bullying incidents: “being called bad names, being threatened, or having lies or bad rumors told about you through an electronic source (e.g., email, chat rooms, instant messaging, websites, or texting).” Response categories were *never, rarely, sometimes, frequently and constantly*. Another question was added to capture incidents of bullying that did not fall into one of the categories mentioned above: “other problematic behavior (please specify).” Therefore, eight questions measure bullying behavior. The internal consistency of this scale for the current sample was .88.

A question to ascertain whether the participant believed the bullying was related to disability status was added: “Do you think the bullying you experienced was related to your disability?” Response categories were: *Yes, No*. If participants selected *yes*, they were be prompted to elaborate in an open-ended response format.

Finally, a question to capture the time frame in which the bullying occurred was added: “during what time in your life did this bullying occur.” Response categories were: *They did not happen, mostly in middle school, mostly in high school, both middle and high school, other (please specify).*

Open-ended questions: The electronic survey included 2 open-ended questions designed to capture protective factors that did not otherwise appear on the survey. The first question was for participants who did experience bullying during middle and high school: “If you did experience bullying in middle school or high school, what factors do you think helped you to cope? Describe what happened. ” The second question was for survey participants who did not experience bullying: “If you did not experience bullying in middle school or high school, what factors do you think helped to protect you from that bullying? Describe what happened.” There was no text limit for these questions, so participants could elaborate as much or as little as they wanted.

Covariates: Participants reported: age, gender, race, type of school attended (e.g., public or private), employment status, geographic location (e.g., urban or rural), diagnosed disability (with the option to include more than one diagnosis), and age at diagnosis for each disability.

Recruitment: Participants were asked how they heard about the study. They were asked to select all the options that applied: *UGA DRC listserv, UGA DRC staff member, or other (please specify).*

Phase 2: Interview

For the qualitative portion of this study, an interview guide was developed based on the results of preliminary quantitative analyses. I began the interview by asking participants to describe their disability and how it impacted relationships with peers, family, and school personnel. Since participants all had a different idea of what behaviors constitute bullying, I included questions about social relationships and school experience to gauge the participant's level of peer acceptance. From there, we discussed the types of interactions with friend and non-friend peers. See Appendix E for the Interview Guide.

3.4 Procedures

Recruitment

Approval for all study procedures was obtained from the University of Georgia Institutional Review Board. Participants for Phase 1 were students who subscribe to the email listserv for the Disability Resource Center (DRC) at the University of Georgia (UGA). At UGA, the DRC serves approximately 1500 students with a range of physical, mental health, and medical disabilities. DRC typically contacts students with announcements and other important issues via the DRC listserv. The only members of the listserv are UGA students served by DRC. For the listserv, letters of support from the listserv administrator accompanied the link to the survey. The survey was anonymous. Participants were given the opportunity to enter a drawing for one of five \$50 gift cards after completing the survey.

The qualitative sample for Phase 2 of this study was recruited from Phase 1 participants. A question at the end of the survey asked whether respondents were willing to participate in an interview. If a respondent checked "yes," they were prompted to list

an email address. There were 53 participants who indicated they were willing to participate in an interview. All were contacted via email to arrange a time and date to do the interview. Of the 53 participants who were contacted, 10 were available and willing to do an interview. Interviewees received a \$25 gift card for participating in the interview.

Data Collection

During Phase 1, data were collected via online survey. Participants were introduced to the study through a brief description that accompanies the recruitment email. Once the link was opened, participants had the chance to read the consent form. Selecting the option to begin the survey indicated consent to participate in the study.

During the Phase 2, qualitative portion of this study, 10 in-depth interpretive interviews lasting approximately 60-90 minutes were conducted. Participants were contacted by email to select a mutually available time and location for the participant and researcher. A university office location was chosen due to minimal distractions, comfort and accessibility. Upon arrival at the interview location, participants read the consent form and I responded to all questions. Participants were informed that they could stop the interview at any time or refuse to answer any questions they so choose. Once the participant signed the consent form, the interview began. With the participants' permission, the interviews were audio recorded. Transcription of the audio recordings took place approximately 48 hours after each interview.

The interview itself was conducted using an in-depth, interpretive style. The purpose of these interviews was to generate in-depth and detailed accounts of the interviewee's experiences (Roulston, 2010). Thus, the questions were open-ended. For

example, many of the interpretive interviews for this study started out with questions such as “tell me about what having disability X is like for you.” In order to generate as much detail as possible, probing questions were used such as “you mentioned____, can you tell me more about that?” The main advantage of using in-depth interpretive interviewing for an emerging area of research is that it gives the researcher freedom to stray from the interview guide and pursue new issues or concepts that arise during the interview (DeMarrais, 2004).

3.5 Data Analyses

Quantitative

To manage the data and perform statistical analyses for this study, I used SPSS for Mac (Version 21.0). A two-tailed 0.05 significance level was used for all statistical tests. Prior to analysis of any hypotheses, I examined the reliability of the scores of the scales. Frequency analysis were also conducted to identify data entry errors and outliers. Chi squares tests were used to compare the categorical variables.

To test Hypothesis 1, frequency analyses of bullying items were conducted. To test Hypothesis 2, I reported the frequency of the question about when it occurred most frequently. In addition, bullying frequency (dependent variable) was compared to the time period during which the bullying occurred (independent variable) using a one-way ANOVA. To test Hypothesis 3, disability types were categorized in two groups: those that affect social skills and those that do not. The group with disabilities that effect social skills was compared to the group with disabilities that do not affect social skills on frequency and type of bullying victimization. Comparison will be made using independent t-tests.

In order to test Hypotheses 4-7, a correlation matrix to examine associations among all variables was compiled. Next, self-reported frequency of bullying victimization was dichotomized into never/rarely and sometimes/frequently/constantly. An ANOVA will be used to compare mean scores for these groups for each independent variable separately (Hypotheses 4-6). For example, mean score of family support for the three types of bullying. To examine Hypothesis 8, a protective factor index was created. Family, peer, and school support, emotional regulation, empathy, behavioral self-control, and self-efficacy will be recoded as follows: 3 or higher = 1, <3 = 0. The protective factor index is the sum of these seven variables. Thus, the index ranged from 0-7, with 7 the highest level of protection. Bullying frequency score was compared to each level of the index.

Qualitative

The open-ended questions included on the survey were coded and emerging themes were analyzed using thematic analysis. Thematic analysis is a process of encoding qualitative information (Obradovic et al., 2012). These themes were used to develop questions for the interview guide used in Phase 2.

Two methods of analysis were used for the qualitative data in this study. The first was induction. Induction is the type of reasoning used to think about qualitative research. Whereas quantitative methods rely on deductive reasoning, qualitative research derives theories and hypotheses after the data has been generated. “Analytic induction asks the following of any event, activity, situation, or attribute: What kind of event, activity, situation, or attribute is this particular one?” (Preissle, 2008). Therefore, I classified my

data into various events (e.g., bullying incidents), activities (e.g., disclosure of the bullying to an adult), and attributes (e.g., disability type).

I also used phenomenological analysis to examine the data. Specifically, I used descriptive analysis, which involved determining the important elements of each interviewee's experience. The in-depth interviews allowed me to identify specific protective factors that aided the interviewee in coping with or avoiding bullying victimization. Phenomenological analysis typically begins with what Dahlberg calls "pre-understandings," which means that researchers must examine their own personal history in relation to the topic of study (Dahlberg, Dahlberg, & Nystrom, 2008). Since people close to me with disabilities have experienced bullying, I acknowledge that I do have personal knowledge of this topic. However, I do not believe it clouded my judgment in terms of carrying out the analysis.

Researcher Role

I did not personally know any of the participants in the present study. Therefore, personal knowledge of participants' backgrounds did not influence my objectivity. Since one of my family members does have a disability, I had more background knowledge about certain conditions than the average researcher. In addition, there were several participants' accounts of bullying that were similar to those that my family member experienced during his childhood. I do not think they drastically altered the course of the interviews. However, in his article about conducting research in one's own community, Aldridge (2011) suggests that researchers must acknowledge the limitations that come with doing research on this population. It is not possible to be a completely objective

researcher, so acknowledging shortcomings is crucial to lending maximum credibility to the research.

CHAPTER 4

RESULTS

This chapter is divided into two sections. The first section presents the results of the Phase 1 student survey, including description of the middle and high school characteristics of the sample, prevalence and type of bullying victimization, protective factors, and open-ended questions. The second section includes the results of the Phase 2 individual interviews, including an introduction to the participants and emergent themes.

4.1 Phase 1: Results from the Student Survey

Table 4.1 shows the school characteristics of the participants in Phase 1. Most of the sample attended public middle and high schools with over 200 students in the graduating class. The schools were most often located in the suburb of a large city (24%). Half of participants reported that they were not receiving any disability accommodations in middle or high school. However, approximately 30% were on either an IEP or a 504 plan during middle or high school.

Table 4.1: Middle and High School Characteristics

	n	%
Size of graduating class		
0-50	16	11.0
51-100	14	9.6
101-200	25	17.1
201-300	30	20.5
301-400	22	15.1
Over 400 students	39	26.7
School Type		
Public	91	48.1
Private religious	36	19.0
Private independent	14	7.4
Homeschool	5	2.6
City		
Large city	13	6.9
Suburb of a large city	45	23.8
Mid-size city	17	9.0
Suburb of a mid-sized city	25	13.2
Town	29	15.3
Rural area	18	9.5
IEP or 504 Plan Status		
IEP	25	17.1
504 plan	24	16.4
Both IEP and 504	4	2.7
Neither IEP or 504	74	50.7
Other special educational services	19	13.0

Objective 1: Prevalence and Type of Bullying

The first objective of this study was to describe the bullying that participants experienced. In order to achieve this objective, the frequency of aggression was calculated, along with characteristics of that aggression.

Table 4.2 details the responses to each of the seven types of aggression. Most of the sample reported low or no physical aggression. Participants reported that being deliberately excluded from social groups was the most frequent type of aggression.

Table 4.2: Aggression Frequency

Aggression Type	Never (%)	Rarely (%)	Sometimes (%)	Frequently (%)	Constantly (%)	Mean (SD)
Being hit, punched, or shoved	78.0	12.6	7.5	1.9	0	0.3 (0.7)
Stolen from	64.6	24.1	10.8	0.6	0	0.5 (0.7)
Being called bad names	38.4	24.5	20.1	11.9	5.0	1.2 (1.2)
Being threatened	72.8	15.8	8.9	2.5	0	0.4 (0.8)
Having lies or bad rumors told about you behind your back	32.9	20.9	25.3	14.6	6.3	1.4 (1.3)
Being deliberately excluded from social groups	28.3	18.2	28.9	12.6	11.9	1.6 (1.3)
Being called bad names, being threatened, or having lies or bad rumors told about you through an electronic source	59.5	16.5	15.8	5.1	3.2	0.6 (0.9)

To obtain a single measure of victimization, the following steps were taken. First, each aggression variables was dichotomized into: *no bullying* (never/rarely) and *bullying victimization* (sometimes/frequently/constantly). The never/rarely group was considered to experience no bullying. Students in the *no bullying* category may have experienced some aggression, but it did not meet the definition in that it was not repeated over time. Second, the two dichotomized items for each type of victimization were summed to create physical, verbal, and relational measures of bullying. For example, the dichotomized score for “being hit, punched, or shoved” and “stolen from” were summed to create the composite physical victimization variable. Third, these scores were then dichotomized into *no bullying* (score of 0) and *bullying victimization* (summed score of 1 or 2). Table 4.3 displays the prevalence of any type of bullying as well as the prevalence by type of behavior: physical (being hit, punched, or shoved; stolen from), verbal (being called bad names; being threatened), relational (having lies or bad rumors told about you behind your back; being deliberately excluded from social groups), and cyber (being called bad names, being threatened, or having lies or bad rumors told about you through an electronic source).

Relational bullying was the most common type of bullying reported by participants in this study (62.7%), followed by verbal (38%), and cyber (24.1%), and physical (18.4%). Almost 69% of the sample reported at least one type of bullying. The results were further analyzed by gender. Table 4.3 displays the percentage of each gender that reported each type of victimization. Three students in the study identified as transgender. Due to the small sample size, their responses were not included in this analysis. Of the participants, 68.5% of the women and 62.6% of men males reported

victimization *sometimes/frequently/constantly*. The difference in the proportion of males and females who reported bullying was not statistically significant, $X^2 (1, N=140) = .186$, $p = .660$. There were no significant gender differences in the number of participants who reported physical, $X^2 (1, N=142) = .190$, $p = .663$, verbal, $X^2 (1, N=142) = .003$, $p = .959$, relational, $X^2 (1, N=142) = .939$, $p = .333$ or cyber bullying, $X^2 (1, N=145) = .739$, $p = .390$.

Table 4.3 Prevalence of Bullying by Type and Gender

Aggression Type	Bullying Victimization		
	Total (n=142) %	Female (n= 113) %	Male (n=29) %
Relational	62.7%	63.7%	51.7%
Verbal	38.0%	37.2%	34.5%
Cyber	24.1%	19.3%	10.3%
Physical	18.4%	19.5%	13.8%
Reported any type of bullying	68.4%	68.5%	62.6%

Table 4.4 displays the participants' perception of whether the aggression was related to the disability. Approximately 40% of the sample reported that they believed the bullying they experienced was somehow related to their disability. Most of those participants reported that it was related to other things as well (e.g., being overweight or sexual orientation). There was no significant association between age at diagnosis and mean levels of bullying victimization.

Table 4.4: Characteristics of Aggression

Aggression related to disability	n	%
Yes, it was related to my disability	16	10.2
No, it was not related to my disability	43	27.4
Yes, it was related to my disability and other things	48	30.6
I did not experience any problematic behaviors in middle or high school	50	31.8

Table 4.5 displays participants' recollection of whether the aggression occurred in middle or high school. Approximately 32% of the sample reported that they did not experience any aggression in middle or high school, which is concordant with the percentage of participants (69%) who reported any type of bullying victimization (Table 4.3). Participants reported that the aggression took place most often in middle school (35%) or in both middle and high school (25%).

Table 4.5 Time of Aggression: Middle and High School

Time of aggression	n	%
I was not bullied in middle or high school	8	7.6
Mostly in middle school	37	35.2
Mostly in high school	21	20.0
Both middle and high school	27	25.7

Table 4.6 displays the prevalence of victimization by disability type. The disability variable was dichotomized into disabilities that impact social skills (i.e., psychological disorder, ADHD, learning disability, pervasive developmental disorder, and acquired brain injury) and those do not impact social skills (i.e., sensory disorder, mobility disorder, systemic disorder, and other ADA-covered disabilities). Disabilities were chosen for each category based on the qualifiers listed in the University System of Georgia disability documentation requirements. A one-way ANOVA was conducted to test for significant differences in victimization between these two groups. There were no significant differences in bullying victimization among participants with disabilities that impacted social skills ($M=0.89$, $SD=0.75$) and participants with disabilities that did not impact social skills ($M=0.89$, $SD=0.84$), $F(1,143)=0.001$, $p=.978$. Participants with

Pervasive Developmental Disorders experienced the highest mean level of bullying victimization ($M=1.23$, $SD=0.83$), followed by Learning Disabilities ($M=1.08$, $SD=0.76$), Sensory Disorders ($M=1.07$, $SD=0.94$), and Psychological Disorders ($M=1.01$, $SD=0.86$).

Table 4.6 Prevalence of Victimization by Disability Type

Disability Type	Bullying Type			
	Sample Total <i>n</i>	Relational %	Verbal %	Physical %
Psychological Disorder	63	69%	38%	21%
ADHD	61	62%	42%	21%
Learning Disability	45	64%	51%	20%
Pervasive Developmental Disorder	13	76%	46%	30%
Acquired Brain Injury	18	44%	22%	11%
Sensory Disorder	21	76%	42%	19%
Mobility Disorder	27	59%	41%	15%
Systemic Disorder	42	57%	36%	21%
Other ADA-covered disability	21	57%	33%	29%

In summary, several hypotheses from objective 1 were supported in the present study. Participants in this study did experience more victimization than in the general population (Hypothesis 1) and bullying rates were higher in middle school than in high school (Hypothesis 2). However, Hypothesis 1a, that males and females would experience different types of bullying victimization, was not supported. Hypothesis 3 was not supported. Participants with disabilities that impacted social skills did not experience more victimization than participants with disabilities that did not impact social skills.

Objective 2: Protective Factors

The second objective of this study was to identify internal (i.e., emotional competence and self-efficacy) and external (family, peer, and school support) protective factors that reduced the likelihood of bullying victimization among children with disabilities.

Table 4.7 shows the correlation among the seven protective factors, as well as bullying victimization. Participants with lower levels of bullying victimization reported higher levels of family support, $r(154) = -.31, p < .000$, peer support, $r(156) = -.21, p = .008$, and school support, $r(155) = .18, p = .025$. None of the internal protective factors (i.e., emotional regulation, empathy, behavioral self-control, or self-efficacy) were significantly correlated with mean levels of bullying victimization. One protective factor (self-efficacy) was significantly correlated with school support. Higher levels of school support were correlated with higher levels self-efficacy, $r(155) = .28, p = .001$.

Table 4.7 Correlation Matrix

	1	2	3	4	5	6	7
1. Family Support	-						
2. Peer Support	.25**						
3. School Support	.35**	.47**					
4. Emotion Regulation	.08	.03	.03				
5. Empathy	-.01	.12	.00	.41**			
6. Behavioral Self Control	.12	-.03	.07	.50**	.38**		
7. Self Efficacy	.10	.13	.28**	.36**	.13	.21*	
8. Bullying Victimization	-.31**	-.21**	.18*	-.02	.03	-.07	-.08

**Correlation significant at the .01 level

*Correlation significant at the .05 level

Table 4.8 displays mean levels of each protective factor as a function of bullying victimization. A one-way ANOVA was conducted to determine if there were significant differences in levels of each protective factor among participants who reported

victimization and those who did not. Participants in the *no bullying victimization* group reported higher levels of family, peer, and school protection, than students who reported any bullying.

Table 4.8 Level of protection by bullying victimization

Protective Factor	No Bullying	Bullying	F	p-value
	Mean (SD)	Mean (SD)		
Family Support	2.25 (0.76)	1.90 (0.79)	6.39	.01
Peer Support	1.91 (0.85)	1.58 (0.89)	4.84	.03
School Support	2.34 (0.67)	2.03 (0.72)	6.34	.01
Emotion Regulation	2.38 (0.56)	2.38 (0.47)	0.02	.96
Empathy	2.62 (0.63)	2.63 (0.50)	0.01	.94
Behavioral Self Control	2.04 (0.69)	2.04 (0.73)	0.00	.99
Self Efficacy	2.25 (0.59)	2.19 (0.61)	0.15	.70

To calculate the combined effect of protective factors, two protective factor indices were created: internal and external. The internal protective factor index was calculated by averaging the 15 emotional competence items. Scores ranged from 0 to 3. Results were divided into four quartiles using the following cutoff score: 25th percentile (<2.01), 25th-50th percentiles (2.01-2.34), 50th-75th percentiles (2.33-2.60), and 75th percentile or higher (>2.60). Results of ANOVA and correlation tests revealed no significant differences in mean levels of bullying victimization for internal protective factor index (Table 4.9).

The external protective factor index was created by averaging the 12 items in the family, peer, and school support scales. Scores ranged from 0-3. Results were divided into four quartiles using the following cutoff scores: 25th percentile (<1.54), 25th-50th percentiles (1.54-2.00), 50th=75th percentiles (2.00-2.41), and 75th percentile or higher (>2.42). Participants who experienced higher levels of external protection had significantly less bullying victimization, $F(3,137)=8.54$, $p<.001$. Post hoc comparisons

using the Fisher LSD test revealed that having more external protective factors was associated with lower levels of bullying victimization. Participants in the 75th percentile of the external protective factor index had significantly less bullying victimization than all other participants, and participants in the 50-75% quartile had significantly less bullying victimization than participants in the 25% quartile.

Table 4.9 Mean bullying victimization levels by protective factors

Quartile	Protective Factors	
	Internal Mean (<i>SD</i>)	External Mean (<i>SD</i>)
<25%	0.98 (0.78)	1.24 (0.87)
25-50%	0.98 (0.74)	1.09 (0.76)
50-75%	0.83 (0.76)	0.88 (0.75)
>75%	0.79 (0.91)	0.41 (0.44)

In summary, several hypotheses from objective 2 were supported in the present study. Participants who reported more external protective factors (i.e., family, peer, and school support) reported significantly less bullying victimization (Hypothesis 4).

However, none of the internal protective factors (i.e., emotional competence and self-efficacy) were related to levels of bullying victimization (Hypotheses 5 and 6).

Furthermore, external and internal protective factors were not significantly related to each other, with the exception of self-efficacy and school support (Hypothesis 7). The external protective factor index revealed that participants in this study had a high number of these protective factors, which was significantly associated with lower bullying victimization levels. Hypothesis 8 was not tested because this study did not include all items need for the calculation from the Social and Emotional Health Scale.

Open-Ended Questions

During the Phase 1 electronic survey, participants answered several open-ended questions about their experiences. These questions were designed to query participants about experiences and protective factors not covered with the quantitative survey questions.

Other aggressive behaviors - Some students indicated if they had been victims of other aggressive behaviors that were not included in the questions from the Retrospective Bullying Questionnaire (i.e. physical, verbal, relational, or cyber). Of the 46 participants who completed this question, 13 reported instances of physical aggression. Examples of physical aggression included tripping, having personal belongings vandalized, and “pulling hair on the bus, trying to pull off hair pieces worn to cover hair loss.” Seventeen participants reported instances of verbal aggression. Examples included “I was made fun of, called ‘weird’. I didn’t have a lot of friends. They laughed at me if I tripped due to my disability” and “constantly being told I was stupid because I couldn’t understand concepts or focus during class.” Several participants reported threats of violence and such as “one girl continuously threatened to kill me during 7th grade” and “calling names, making up mean nicknames.” Relational aggression was the most common form of aggression cited in this question. Examples of relational aggression included “excluded from friend groups, looked at differently” and “people went out of their way to exclude me...people would organize events and tell me the wrong day or place deliberately.” Several participants reported rumor-spreading about their disability: “rumors were spread that I was making up my disability to get attention

and that I was faking it” and “some of my peers believed I was faking or exaggerating my disability and would tell this to others so they would not support me or include me.”

Several participants reported multiple types of aggression: “Since I’m in a wheelchair, back-packs were constantly shoved in my face, I was cussed at when people ran into me, and when I asked politely for someone to get something for me, there was normally a negative attitude with it.” Three participants in the sample identified as transgender, and several reported this was a component of the bullying they experienced:

I received harassment often for my gender and sexuality in addition to my disabilities. Male classmates would often harass me, tease me, and make purposeful statements in class to upset me. They would instigate arguments or act difficult during group projects then blame me for lack of participation. Because I was being ‘mean’ to them. I experienced them speaking loudly about me, calling me names such as ‘bitch.’ Female classmates would speak directly to my friends about how much they disliked me and would act cold toward me even though I was polite. I was called names, threatened, and generally harassed throughout middle and high school.

Reasons for aggression - The second open-ended question in the electronic survey was: “why do you think you experienced these aggressive behaviors?” Of the 96 participants who answered this question, 55 reported their disability as a reason for experiencing aggressive behavior. Sometimes this was a direct target on the disability, such as making fun of someone for having seizures or walking differently, but sometimes participants were targets because of the way they acted. The participants who were targeted for the way they acted most often had “invisible” disabilities such as Asperger’s

Syndrome or ADHD. Several participants reported their disability influenced the way they acted in class, which made them a target:

I acted out in class when I didn't want to work. Many things stressed me so I tried to control the rest of the world around me to manage my stress. Bullies found it humorous. I was always be the last one to finish in class, on either quizzes, assignments, or busy work. Other peers would get frustrated, and it was embarrassing. Also emotionally along with mentally I was not as mature as others my age so I was picked on multiple times.

Many participants described having difficulty with social interaction due to their disability, which resulted in bullying: "I have Asperger's, so I really struggle with social interaction" and "I was shy and quiet. I was really awkward in middle school and had trouble fitting in/relating to other students" and "I believe I experienced those things because my severe anxiety made me an easy target."

Factors that helped cope with bullying - The third open-ended question on the survey was: "If you did experience aggressive behaviors in middle school or high school, what helped you cope?" The most commonly reported coping mechanisms were support from friends and support from family. Of the 91 participants who answered this question, 22 mentioned friends as a coping mechanism for bullying victimization: "My friends were also very understanding and helped me by coping with humor. My friends and I came up with jokes about my disabilities and sexuality that made it easy to laugh about the experiences I had in school." Family was a commonly reported coping mechanism as well. One participant stated that the support from her family was one of the only things to give her hope that things would get better:

Mental strength and my parents. No matter how much I got in trouble or how much my parents talked trash about each other, my stepfather, father, and mother all supported me and praised me for my talents. They were always there for me so even though I had no one else, I had my family. They saw my potential and always reminded me of it, giving me hope that someday things would be better. Other coping mechanisms mentioned by participants were participating in sports, pets, religion, listening to music, reading, and psychotherapy.

Factors that protected from bullying - The last open-ended survey question queried participants about protective factors: “if you did not experience aggressive behaviors in middle or high school, what protected you?” Answers to this question (n=89) tended to revolve around 3 themes: friends, family, and school. Friends were mentioned in 22 separate answers. Examples include “I experienced very little aggressive behavior mostly because I had a lot of friends that would back me up if I ever felt uncomfortable in a situation” and:

I had a close group of friends that I grew up with. Those friendships were consistent throughout middle school and high school. We lived near each other and I suppose we were fairly popular. We were all fairly athletic and we participated on the school sports teams, which gave us a larger group of friends. In addition to peers, family was frequently (n=7) cited as a source of protection from bullying victimization. Several participants mentioned having a popular older sibling at the same school to be helpful “I also had a popular older brother (he was two grades above me at school), which I think was helpful” and “My older sister absorbed a lot of it [bullying] for me. She basically had an intimidation campaign against my bullies in high

school.” Many participants recognized that their school climate and school rules played a role in their protection from victimization. For example: “The school I attended had a very strict no tolerance policy. Also everyone was mostly wealthy and well-mannered in such a way where bullying and fights were rare.” and “Strict school rules. A general school culture that didn't promote bullying—if people could actually connect the dots and realize that something was bully-type behavior, it would be seen by pretty much everyone as bad form.” However, school policies did not cover all types of bullying behavior: “rumors, however, were common and not something a person could be penalized for.”

Additional themes from open-ended questions - Four themes emerged during the analysis of the open-ended survey questions. These themes were not specifically addressed in the survey, yet emerged in the narratives of participants. The themes were: normalizing aggression, difficulty with advocacy, lack of peer understanding of disability, and blending in with peers in order to gain peer acceptance.

The first theme was participants’ tendency to normalize the aggression they experienced. For example, one participant wrote that aggression was a normal thing to experience in middle school, “it was middle school, things happen” and several other participants wrote “boys will be boys” and “girls will be girls.”

Sometimes disability characteristics made advocacy difficult, as the example from this participant with Generalized Anxiety Disorder illustrates: “my paralysis regarding social events and people made me the easiest target, and I was too terrified to stand up for myself.”

Some participants felt their peers did not understand their disability. Due to lack of understanding, some felt they were excluded because peers did not know how to accommodate their disability:

Deafness affects people socially. A few boys called me names in middle school (but I didn't hear them, others filled me in) but the bigger issue was exclusion. It is extra work to make sure the "deaf girl" can hear what's going on, to make her feel welcome, and to consider if she would even have fun doing whatever it was they were planning to do. I think it was easier for them to just not invite me than to try and work out the details. Honestly, while it was hurtful, I probably would have done the same thing.

Participants with invisible disabilities (e.g., Type 1 Diabetes, ADHD, Learning Disabilities) experienced ostracism from peers who thought they were trying to avoid work or school responsibilities: "Some of my peers believed I was faking or exaggerating my disability and would tell this to others so they would not support me or include me."

One frequently occurring theme among participants was "blending in" in order to fit in with peers: "I tried my best to hide my disability at all times" and "my goal was to not be noticed by anyone." For some participants, this strategy led to social isolation: "my disability was never an issue because I hid it for various reasons. This led to a lot of isolation and other issues, but was necessary." For others, blending in resulted in more friendships "nobody could tell I was different."

4.2 Phase 2: Results from the In-Depth Interviews

The contextual inquiry (objective 3) for this study was conducted to explore and identify themes of bullying victimization and protection from the perspective of the

participants. Ten in-depth, interpretive interviews were conducted. In this portion, I begin with an overview - why am I providing these narratives? What is the purpose? I provide context for their reports and bullying. The analysis of each interview began with transcription. I used Express Scribe in order to listen to each interview at a slower speed. I set the playback speed at 40-60% of the original speed, depending on audio quality and clarity of each participant's speech. I listen to each interview several times before transcribing. Each time I listened, I took notes when themes and other items of significance emerged. During transcription, there were several points in which participants' speech was inaudible; these instances are noted with "(??)" in the transcription document. The results from contextual inquiry will be presented in two sections: an overview of participants and major themes.

Overview of Participants

Ashley - Ashley was the first interview participant for this study. She came into the office for her interview out of breath and excited to talk about her experiences. Ashley disclosed that she receives accommodations at the disability center for multiple psychiatric and attention-related disabilities. Her first diagnosis was made during middle school, and the most recent during college. Ashley said the symptom that had the biggest impact on her life was severe mood shifts. She described feeling distinct shifts in her mood, like "shifting the gears in a car." The shift occurred between three different moods "It was either like the highest of highs, nothing could ever go wrong I'm so happy life is so good but then pair that with complete sadness nothing is ever going to go right with me in my life everyone hates me, and then there was the anger where I was just mad at everyone." These mood shifts could make interacting with people difficult because she

would have unpredictable reactions. Ashley reported many instances of relational aggression, starting in elementary school and continuing through to the present day.

Buddy - When Buddy walked into the office for our interview, he immediately came across as a very intense person. He walked and talked very fast, and appeared to have a great deal of energy. Buddy was diagnosed with attention and processing disabilities in the third grade. His mother played a large role in his diagnosis and made sure he got all the accommodations he needed. He noted that he did not think it influenced his daily life, except for the fact that it takes him much longer to do assignments than his same-age peers. Buddy has been taking daily medication for attention for 16 years and feels that his symptoms are well controlled. However, he stated that sometimes “like some people comment on my tendency to fidget or go off on rants. Sometimes I get excited and start kind of speaking very loudly without realizing it.”

Sarah - Sarah was diagnosed with an attention-related disability a few months before our interview. She had obviously done a lot of reading about her diagnosis in those months, because she recounted her symptoms to me using very formal language (e.g., “I’m hyper verbal and have impaired auditory memory”). She reported having trouble with organization and following directions. Her diagnosis was brought about because her father was recently diagnosed and noticed a lot of the same symptoms in Sarah. She reported that her father’s culture played a role in the delay in his diagnosis. She stated that in his culture “they don’t care about your problems unless they are physical, if you have a mental problem, it doesn’t matter.”

In contrast with many participants in this study, Sarah did not report any difficulties with friendships. In fact, she said that during high school, she had many

friends and was involved in a lot of activities. Sarah went to a very competitive school in which she reported a large amount of pressure to take advanced placement classes and to make a high grade in every class. Her attention difficulties affected her ability to perform in some classes, which impacted her classmates' perceptions of her. One course that she reported particular trouble with was physics. When she had trouble understanding despite a large amount of effort, a friend said to her: "Sarah, physics is easy, get with the program. Nobody wants to work on projects with you because you get such bad grades."

Jason - Jason arrived at the office for our interview in a cheerful mood. He spoke with the confidence of someone who was used to projecting his voice to a large group of people. Jason reported that he is registered with the disability services because he has attention difficulties. According to him, this means "there are some factors that aren't the typical profile [of the disorder] but it's enough to reach that threshold." Jason noted that he does not think he has the symptom of physical hyperactivity, but he reported some "mental hyperactivity." In addition, he experiences slow cognitive processing speed, and was able to remember that he scored in the 34th percentile on this measure during his diagnostic testing. At the time of the interview, Jason was taking a low dose of a stimulant medication to improve his attention and reported that he thought it was helpful.

Jason was formally diagnosed during graduate school, but he suspected that he had the disorder approximately 10 years before his diagnosis. During his time in college, he worked with children who had attention problems and noted many similarities between himself and those children. With the benefit of hindsight, he remembered "this kind of feeling of mental dullness, foggiess" from early elementary school. He reported difficulties with organization and "keeping his room clean" as a child. Jason had

significant problems with handwriting during school, and was diagnosed with a handwriting disability. He reported “there is no consistency between one ‘H’ that I draw and another ‘H’ that I draw and almost generally it should have some consistency between the letters.”

Jason’s attention-related symptoms did create some problems during his childhood. His father is “very detail oriented and very focused on these things [details] and has a military background to add to that.” Jason’s difficulty with organization was the source of a lot of conflict with his father, although he reported that his mom was “a lot more understanding about these things.” As for peers, Jason encountered many instances of bullying at school. He recounted episodes of physical, verbal and relational aggression.

Tyra - Tyra has a severe anxiety disorder and “it makes me really nervous in a lot of situations”, she worries about “basically everything” and she will “sometimes cry about things for no reason.” She said that it affects her sleep (i.e., sleeping too little or too much) and reported having a panic attack during preschool when the teacher skipped over her during snack time. She reported that she knew that she was different since the age of 2, but she received an official diagnosis at age 16. Tyra had to convince her mother that she needed to see a therapist because of her difficulties with friendships and social interactions. The therapist made the initial diagnosis.

Tyra was very tearful during many parts of the interview when she was recounting incidents of bullying. She reported being very isolated during elementary school and having no friends. However, she indicated that during middle school, she started imitating the popular girls at her school. She would dress like them and act just as

they acted. As a result of these efforts, she “became really popular, people wanted to be around me.” When asked why, she said that her strategy was to just let them talk, and validate what they said, and they wanted to be friends with her.

Anna - Anna was diagnosed with an endocrine disorder at the age of 11. She is currently 20 years old and has been living with the disease for almost 10 years. Anna was diagnosed at a point when she was sleeping more than usual, was irritable toward friends and family, and was drinking 6-7 gallons of water a day (i.e., typical symptoms of the disability). Upon testing her blood sugar, the doctor informed her that it was almost 6 times what is considered to be a normal value. This occurred several weeks before she started middle school. She described living with her disability as “it means you’re constantly thinking and aware of what you’re eating, how you’re feeling, just what you have going through your body, how much more you need to put in, what your numbers are, lots of math in your head all the time.”

Anna reported that her disability had an impact on her friendships. Her parents always had to know whom she was with and where she was going. They had to call her friend’s parents to ask that they make sure Anna checks her blood sugar, which Anna reported as being “super embarrassing.” However, Anna indicated that her friends were very supportive of her needs and were always willing to accommodate her disability. Anna reported that, while her friends and parents were always willing to accommodate her, she did not have the same experience at school. She felt that the school was annoyed and burdened by her need for a place to store her medication (i.e., somewhere other than the faculty lunch refrigerator) and to carry her blood sugar monitor with her even though the school had an electronics ban. The school instituted a rule that Anna was not allowed

to travel anywhere alone, for fear that she would need help. Anna felt embarrassed by this because every time she needed to leave class to use the restroom or go to the nurse, the teacher had to stop class and ask who would accompany her.

Becca - Becca arrived at our interview several minutes early and appeared to be thrilled to talk to someone about her experiences. Our rapport was almost immediate because of her open nature and our mutual understanding of Becca's disability, an endocrine disorder. She gave a thorough and accurate explanation of her disability, saying it was "where your immune system attacks insulin-producing cells in your pancreas and you become insulin dependent until there is a cure." She was diagnosed with her disability at age 7 after several months of frequent illness, increasing thirst, and frequent urination. Her mother took her to the eye doctor for a routine visit and the doctor noticed that she had blood vessels bursting in her eyes, a symptom of extremely high blood sugar.

Becca reported that her disability has had a profound impact on her life. In order to regulate her blood sugars and insulin levels, she developed a rigid schedule of waking up at the same time every day, checking insulin and blood sugars multiple times a day, planning meals around medication administration, and having to check blood sugar and insulin levels before engaging in any physical activity. If her blood sugar is not regulated, it was very difficult for her to concentrate, write, and pay attention in class. Becca was incredibly passionate about advocating for people with her disability. She has ambitions of going to law school and becoming a lawyer to work in disability rights law.

Jamie - When Jamie entered the office for her interview, I saw an athletic, healthy-looking college student who appeared to be incredibly happy and energetic. She

was wearing exercise clothes because she was going to the gym after our interview.

Jamie was diagnosed with a brain tumor at age 6, and had surgery to remove it during high school. She described an incident that occurred at age 6 in which she was taking a bath and became unconscious. Her family was unable to wake her, which led to an emergency room visit, brain scan, and discovery of the tumor. The tumor was attached to the hippocampus, and the surgery to remove the tumor resulted in memory, speaking, and vision impairment.

Jamie spent a significant portion of her childhood in the hospital, getting various scans and tests to determine whether the tumor was spreading. These frequent hospital visits took a toll on her social life: “it was really hard like friends wise, I just felt like I was really alone physically and psychologically. I just felt separated from the world.” Jamie felt isolated during those hospital stays because her family was usually not with her. Both of her parents worked long hours due to financial concerns regarding their mounting medical bills. However, Jamie indicated that she felt inspired by all of the patients she met at the hospital during her many stays. These other “regulars” at the hospital became her support network during her many procedures.

Lindsay - Lindsay approached me to conduct the interview looking very polished and professional. She wore slim-fitting black pants, ballet flats, and a short-sleeved silk blouse. Lindsay was very quiet and deliberate in her speech. I had to use a lot of probes to get her to elaborate on her experiences. Lindsay was a graduate student at the time of the interview and reported that she had a disability that resulted in chronic, severe pain. This disability stemmed from a sports injury at during high school and lasted until she completed her undergraduate degree. During her final year of college, she was diagnosed

with a learning disability. Lindsay underwent 4 surgeries to repair the injuries she sustained during basketball. Following surgery, Lindsay was in a wheelchair for several months during high school and crutches for several months after that. To recover from the injury, she went to physical therapy for 2 years. Her chronic pain disability was diagnosed approximately one year after her injury and was because her pain level was much higher in intensity and duration than was typical for her injury. She reported that the pain was initially only in the knee area, but progressed to other areas of her body. Lindsay said she experienced her disability as “significant pain with very little touch and sporadic incidents of pain with no actual cause.”

Lindsay’s disability had a profound effect on her life. She reported that all of her grades dropped at least one letter grade. As a result of her disability, Lindsay could no longer participate in sports for the duration of her high school career. She played a sport during every season so this significantly changed the people with whom she socialized. Lindsay reported that she was the star player on her school’s soccer team, and her teammates were upset that she could no longer play. Sports were a large part of her school’s identity and she felt that many people at the school no longer valued her when she couldn’t contribute to the soccer team. Lindsay felt that none of her teammates understood why she could not play but that several adults at the school were supportive and were willing to listen if she needed to talk.

Krystal - Krystal came to our interview after being dropped off by her personal care assistant. She introduced herself with a sunny disposition, and acted much older than her 18 years. When the interview began, Krystal told me that her disability was congenital and resulted in significant mobility limitations. She was diagnosed at birth and

has been in a power wheelchair since early childhood. According to Krystal, her disability results in a gradual loss of muscle function and respiratory distress. Krystal reported that she needs assistance from a personal care attendant with tasks of daily living such as opening things, doing her hair, going to the bathroom, and getting around campus.

Krystal's disability has had an impact on every area of her life. She reported having a hard time relating to same-age peers because she does not experience the same things that they do. Krystal needs to have at least one aid with her when she goes out, and at least 2 aids if she might need to use the restroom. This added extra stress when making plans. During her school days, she had to ride a different bus than her classmates going to school and on field trips. When she would ask a peer to sit with her on the bus, school staff said no so they could keep track of all students. Another impact of her disability has to do with mobility. To help me understand this, Krystal explained the distinction between ADA compliance and reality. When using an ADA compliant restroom, the sink is required to be at a certain height, but Krystal reported that it is still very difficult for her to reach the soap and the faucet because she limited range of motion in her arms. Despite the difficulties, Krystal reports really enjoying college. "In college they want you to be here, you add diversity to the school. In high school and middle school they have to accommodate you and you're a burden."

Major Themes

Major themes that emerged from the analysis of interview data are presented below. First, I present themes from each individual research questions followed by other themes that emerged during analysis. There were 3 main themes that were generated

through the analysis of the interviews. The themes were: participants experienced multiple forms of victimization, there was a reluctance to report victimization, and many different support structures existed to cope with and prevent bullying victimization.

Multiple types of victimization - Participants experienced the three main types of bullying during middle and high school: physical, verbal, and relational, as detailed below.

Most participants did not report instances of physical aggression. However, those participants who did report physical aggression indicated they remembered these instances very well. Jason described an event that had not crossed his mind in a long time:

A guy who was much larger than me weight-wise....I didn't even see it coming, he just ran up behind me and just knocked me over on my face and just laid on top of me and tried to shove my face in the snow. And I remember that because I remember feeling like I couldn't breathe.

Tyra was one of the only females in the study to report instances of physical aggression. She described how the bullying she experienced started out as verbal and relational, then developed into physical aggression: "someone glued paper to my hair once, I think it was fourth grade, there were these two girls and even though on the bus two girls on the bus acted like they were so caring, but they only sat with me once."

Jason described many instances of verbal aggression during middle school. He said the insults usually followed a theme: "I was usually called a name that related to some type of bodily function, like butt face." Tyra described how she thinks her bullying started as relational, and then evolved to verbal: "I think people just pick up on it when

you talk behind their back, they just know and eventually the more and more people talk about your behind your back, the more and more it is ok to do it to your face because everyone else has agreed that you just aren't cool enough."

Other verbal aggression occurred among multiple participants, which was disability-related. Several participants reported being accused of faking or exaggerating the symptoms of their disability in order to avoid responsibility or get special treatment. Lindsay, Becca, Jamie, and Anna all described direct verbal aggression related to their disability accommodations. For example, when Anna had to leave class because of low blood sugar, one classmate said, "I bet nothing is wrong with you, you just want to get out of class." All participants that described this direct verbal aggression had systemic, medical disabilities (i.e., Type 1 Diabetes and Chronic Regional Pain Syndrome). Jamie recounted a conversation that occurred between two classmates about why Jamie was missing school:

She has to have surgery, she has a brain tumor and that's why she's never here at school' and that girl that I used to cheer with she was like, 'Oh, she's just faking it' and everybody is like, 'What?!' and she was like, 'Yeah, she's just doing it for attention, she brags about her tumor and wants people to feel bad for her. She says she's going into the hospital but I'm sure she's like perfectly fine.

Relational aggression was the most common form of aggression reported by participants in Phase 2. Ashley reported that this was the main type of bullying she experienced: "Oh tons of people talked behind my back. This girl named Jill. She would pretend to be my friend to my face but then she would constantly spread rumors about me." Ashley had other friends that would "try to sabotage my relationship with other

friends by spreading lies about me.” Jason reported his sheltered, religious family background made him a target of relational aggression. He was homeschooled until the fourth grade and reported having little awareness of the social rules in his new school. Jason felt this was the reason he was excluded from many activities with his peers.

Anna reported relational aggression that took place online during middle school: Social media is like the worst especially in middle school. Just like “Who is your top friends?” would cause so much stress, and then someone said I was copying them or something their whole life. And in some shape or form in very vague posts like you knew they were about you, I’d get that like along with everyone else in the group. So, I think that was the worst part.

Participants experienced other types of victimization in addition to bullying. The most commonly reported type of victimization (other than bullying) was dating violence. Tyra described a relationship she had during high school with a boy who “didn’t understand my disorder.” Tyra’s anxiety caused her to cry and become very anxious when she was over stimulated. Her boyfriend at the time reacted to this display of emotions in the following way:

He was just so mad at me because I couldn’t stop crying. He would constantly tell me how disguising and weak I was or that I was embarrassing him, how uncool I was. Just all these things that I was just doing – he was so mad. He wouldn’t talk to me, he just wanted me to get over it. And I couldn’t.

Tyra reported that the relationship ended during the last semester of her senior year in high school. “He ended up breaking up with because I was too emotional and crazy and that I couldn’t make decisions for myself because I was too crazy.” Ashley reported a

violent dating relationship during high school. The relationship ended when her boyfriend started spreading rumors that she was “crazy.”

Reluctance To Report Victimization

Jamie reported that the fatigue and intensive treatments she underwent for her brain tumor had an effect on bullying disclosure. She reported some relational and verbal aggression from her classmates to a teacher. When the teacher asked if Jamie would like her to talk to the perpetrator and Jamie said no:

I just felt like that the tension would have just risen and I couldn’t handle...I was already like in the hospital at the time and missing like three or four days throughout the week of school. I had to juggle like school and extracurricular and I was like, “No, it’s really, fine, I want to drop it”maybe if it was like last year or another year but at that point I was just... Yeah, I didn’t have the energy to sit there and confront her or even talk to the counselor about it.

During Buddy’s interview, he mentioned that no one at his school reported bullying to adults because “it made the situation so much worse.” He described other students being ostracized and teased for being “tattle tales” and “weaklings” for relying on adults to solve their problems.

Support Structures

Many interview participants mentioned sources of support during middle and high school. These sources of support ranged from entire schools to summer camps to individual family and friends. Several interview participants (Ashley and Tyra) went to general education, public schools in middle school. They both transferred to different high schools either as the result of moving for a parent’s new job (Ashley) or for

unspecified reasons (Tyra). Tyra initially transferred to an arts-focused high school, then to an International Baccalaureate School. She reported more peer acceptance and less anxiety due to the accepting nature of both new schools: “it was art school, no one wanted you to be quiet. I was pretty much always happy... it’s wonderful because you feel completely at ease and they are all just understanding.” Ashley transferred to an International Baccalaureate school, which had stringent academic admission criteria. She made many friends at this school and felt that the adults “just understood how gifted minds work, it was ok to be different.” At one point during the interview, Ashley started crying because she realized how much the school meant to her and how much she missed it.

Several other participants found support in summer camps for children with the same disabilities. Both Becca and Anna attended camps for children with Type 1 Diabetes. Both reported that attending camp was a life changing experience for them. Anna said:

So, the first two years of having the disease I didn’t even think anyone else in the world had it. And so like going there and being in a cabin full of twelve year olds who all had it....that was really when my whole viewpoint turned around. “Look at all of these people who have it, look at that girl, she’s cool, she has it”....and so that was really good.

Anna described her time at camp as being the only time she didn’t feel different from her peers, because “every single kid in the camp is checked on blood sugar and every single kid is taking a shot.” Both Anna and Becca attended camps in the same state in which they lived, so they were able to maintain close ties with other campers throughout the

year.

Other participants described protection from older siblings. Jason felt that having an older brother at the same school was protective for him: “when people were teasing and harassing me when I was in school, he was always like, “I’m going to go school and beat those people”...and so he was pretty protective of me.” However, Anna thought having an older brother was not protective for her. She mentioned being much closer to her brother now, but in middle school and high school, their age difference was so large (4 years) that they didn’t have anything in common.

One commonly reported protective factor was “blending in” with peers. Tyra described having social difficulties in middle school, until she decided to start imitating her peers:

I couldn’t really get the other girls to talk to me, so I ended up just talking to myself and creating imaginary friends, we never could really communicate. It never really got much better. I just grew more socially awkward. I started to really watch people and copy exactly what they would do. Be completely someone who I wasn’t. I was trying to copy what the other girls were doing. I would just copy and paste. I got rid of everything and only wore what the other girls were wearing. And that actually worked. I became fairly popular. But my personality was still really weird – I was still really depressing, I just couldn’t say a positive thing, because everything was just a big fear or concern or worry. So I learned to just stop talking, and so....middle school was actually the easiest time for me. As far as friends go, it was the easiest. Even though I didn’t have any friends, you just sit there and let them talk. As long as you can get other people talking –that’s what

people like.

Hiding one's disability and blending in was Ashley's strategy for peer acceptance after she disclosed her disability to friends. Ashley told a friend about her recent suicide attempt and was met with hostility and name-calling. After this reaction, Ashley did all she could to hide her disability and asked her friend not to disclose this information to other peers. Buddy hid his disability by not using all of the accommodations that were available to him during middle and high school. He stated some of the accommodations were "kind of intrusive, like having a teacher use a tape recorder." In hindsight, he realized that this accommodation would have made school easier for him, "typing could've been helpful when I was in middle school but in elementary school, but I refused it. I don't know why I did that. And in hindsight, I was like, "What the hell was I doing spending all day typing?"

According to Becca, having the support of family and peers was helped development of the confidence she needed to advocate for herself. "Having people not necessarily stick up for you but stand by your side made it a lot easier to combat bullying or ignore it than doing it by yourself." Both Becca and Anna developed a strong support network of friends from diabetes camp. Even if they did not attend the same school, many of the campers kept in touch and would socialize after school and on weekends. Anna described having many difficulties with friends at school, but having the support of her camp friends made her more confident.

Having a supportive family was a very important protective factor for many participants. Buddy described his parents as "very motivated in terms of making sure that we [my brother and I] had whatever we needed to succeed." When he received his

diagnosis, his mother “became this sort of self-motivated researcher on learning disabilities and ADHD and so she’d look up resources.” These resources allowed Buddy to get all the accommodations he needed, which resulted in his success in school. Having confidence and success in school resulted in greater confidence in social situations. Buddy recalled that his friends knew about his disabilities, but his confidence allowed him to state that he got accommodations and “it was no big deal.” In turn, his friends treated his disability as “no big deal.”

Finally, several participants reported that educating peers about their disability was empowering and helped to foster good relationships. Becca educated many of her peers about Type 1 Diabetes “I would always try to explain what diabetes was to my classmates. I’d ask my teachers ‘hey can I teach them about diabetes?’ and that helps. I think educating my peers did make a big difference.” However when the participant’s disability was not perceived as a physical or medical illness, the education process was different. When Ashley disclosed her diagnosis of Bipolar Disorder to her friends, “all their attitudes were that mental disorders don’t exist, that it was just made up and that I am crazy.”

Many participants in the present study reported support from peers and families in relation to bullying and to their disability. Conversely, there were several who did not feel they had support of administration and staff at school. Anna described great difficulty getting the school to accommodate her Type 1 Diabetes:

For the longest time it was against the rules to have my like my meter on me which is pretty dangerous because I’d be on the third floor and they’d have to keep it in the nurse’s office and we didn’t have a nurse and so I’d like have to get

someone to unlock the door for me and then go in and then check my sugar and so by then I could've easily been gone. That's like a thirty-minute process to go get my meter.

Anna reported that she and her parents spent 3 years trying to convince the school to let Anna carry her blood glucose monitor in her backpack, because diabetics need to check blood glucose multiple times per day. Having to wait 30 minutes for a staff member to open the door and retrieve her blood glucose meter was potentially very dangerous in the case of very low or very high blood glucose levels (e.g., losing consciousness, seizures).

Lindsay reported difficulties from school staff, but in her case she experienced hostility from school personnel because her disability prevented her from playing soccer on the school team. Lindsay was one of the top performing players on the soccer team and when she injured her knee and could no longer play, peers and school staff were initially very supportive and encouraging in her recovery. However, when she developed Chronic Regional Pain Syndrome after her knee surgery and took much longer than expected to recover, many sports enthusiasts at the school accused her of “not trying hard enough” to recover.

Krystal was the participant in this study with the most mobility limitations. Since she has been in a wheelchair her whole school career, Krystal has experienced much hostility from school staff related to her accommodations. She recounted a story in which her class went on a field trip. Krystal required transportation that was wheelchair-accessible, which meant that she was on a separate bus from the rest of the class. When she asked if a classmate could sit with her on the otherwise empty bus, the school staff told her no. The school forgot to designate two staff members to help Krystal on the field

trip, the number that is required to help her use the restroom. When she had to use the restroom on the field trip, there was only one staff member there to help her. Krystal described feeling humiliated because her younger sister, who was on the same field trip, had to help her use the restroom.

In summary, participants in the interview portion of this study (Phase 2) described experiencing physical, verbal, and relational aggression during middle and high school. Very few participants reported positive outcomes from disclosing bullying victimization. Most participants reported that they avoided disclosure for fear of retribution. Participants reported experiencing protection from bullying victimization from blending in with peers, having the support of family and peers, attending schools with like-minded people (e.g., art school), and attending summer camps for children with similar disabilities. Finally, several other themes from this data including victimization from school personnel and dating violence victimization from dating partners.

Triangulation of Quantitative and Qualitative Data

Triangulation of the quantitative and qualitative data from this study was conducted to integrate the findings and gain more insight into the issue of bullying among students with disabilities. Participants in both phases of the study were similar demographically: there were more females than males, most were between the ages of 18-23, and almost all reported attending public schools during middle and high school. Survey participants reported an average of 2 disability diagnoses, but only 3/10 interview participants had more than one diagnosis. It could be that students with high greater levels of impairment from multiple disabilities elected not to participate in the interviews. The most prevalent disabilities among survey participants were Psychological Disorders,

ADHD, Learning Disabilities, and Systemic Disorders. These were the most prevalent disabilities among the interview participants.

Overall, the survey results suggested that students with disabilities experienced high rates of physical, verbal, and relational bullying victimization. Further support for this finding was found in the in-depth interviews.

These students reported multiple protective factors from friends, family, and school personnel. Higher levels of peer, family, and school support were associated with lower levels of victimization among survey and interview participants. Data generated from interview provided more understanding about how each of these groups was supportive. Peers were supportive because they intervened when bullying was taking place and provided protection to reduce victimization. They used strategies such as humor to help participants cope with bullying victimization. The influence of family on bullying victimization was mostly felt by participants in their level of confidence to advocate for themselves. Participants reported advocating for themselves in the case bullying and for their disability-related needs. For example, Anna and her parents were very involved in getting the school to change their “no-electronics” policy so that she could carry her blood glucose meter in her backpack. When Anna saw her parents stand up for her, she found the voice she needed to do the same for herself. In terms of school support, most participants in both phases felt supported based on school climate. The participants who felt the most support from school reported that school was a safe place where bullying was not acceptable. Being able to report the bullying to a teacher or other school staff member was not helpful because, according to interview participants, it would exacerbate the problem and could potentially cause more victimization.

Participants in both Phase 1 and Phase 2 indicated they sometimes felt victimized or misunderstood by school personnel. This finding was unexpected and was not something included in the electronic survey. However, several participants described this victimization in the open-ended questions of the survey. As a result, I included a question about this type of victimization in the interview. Participants reported lack of support for their disability-related needs from many school staff members. Some reported hostility from school staff when they tried to advocate for their disabilities.

CHAPTER 5

DISCUSSION

The purpose of this study was to identify internal and external protective factors that protected students with disabilities from bullying victimization during middle and high school, and to identify whether a single protective factor or multiple protective factors were most influential. It was hypothesized that participants in this study would report higher prevalence of victimization than students without disabilities and that the aggression would take place most often in middle school; that females and males would report different types of aggression, and that participants with disabilities that impacted social skills would report the most victimization. I also hypothesized that stronger family, peer, and school support; emotional competence, and self-efficacy would report lower levels of bullying victimization and the combined effect of these protective factors would results in lower bullying victimization than any factor individually.

While the prevalence of bullying victimization among U.S. students without disabilities is between 20-28%, the prevalence of bullying victimization among participants in this sample was over twice as high, with two-thirds reporting bullying victimization during middle and high school. Prevalence estimates for bullying victimization in children with disabilities vary widely, with estimates as low as 7% and as high as 94% depending on type of disability (Kaukiainen et al., 2002; Little, 2002). The results from the survey and the in-depth interviews support the high prevalence of relational aggression. Physical and cyber bullying were much less frequent among

participants in this sample. The bullying reported by participants in both phases tended to occur most often in middle school. This study adds clarity to the sparse literature on prevalence of bullying victimization among students with disabilities. The high proportion of female respondents in both phases may partially explain the high rates of relational aggression. Research indicates that girls are more likely to be victims of relational aggression than boys (Orpinas et al., 2014).

Contrary to my expectations, participants in this sample who had disabilities that impacted social skills did not experience higher rates of bullying than participants with disabilities that did not impact social skills. One possible reason for this finding could be that participants in this study were particularly high functioning, as they were studying at a selective university. This population may have more protective factors (e.g., extra help developing social skills) than a group of people with disabilities that are not in college.

In spite of this negative result, participants with different diagnoses reported varying degrees of victimization. Participants with Pervasive Developmental Disorder were among those that experienced the highest rates of each type of bullying victimization. Participants with Pervasive Developmental Disorders (76%), Psychological Disorders (69%), and Sensory Disorders (76%) experienced the most relational bullying. The disability types that experienced the most verbal bullying were Learning Disability (51%) and Pervasive Developmental Disorders (46%). Physical bullying was the least common form of bullying among participants in this sample. However, 30% of participants with Pervasive Developmental Disorders experienced physical bullying victimization. These findings complement the current research

literature on children with Pervasive Developmental Disorders, which indicates that up to 94% of these children experience bullying victimization (Little, 2002).

Although the study did not examine violence from dating partners, several participants in the qualitative inquiry revealed verbal (i.e., name calling) and relational aggression (i.e., rumor spreading, gossip) from their high school boyfriends. Relationship violence among adults with disabilities is a well-documented phenomenon, but violence in teen relationships is an area in need of further study. At the time of this writing, only one study examining dating violence among adolescents with disabilities was found. In this investigation, 98 adolescents with psychiatric disorders in Australia were studied and results indicated that 13% of the sample experienced physical dating violence victimization A. Brown et al. (2009). No studies have examined verbal and relational dating violence, as that experienced by participants in this study.

The overlap among types of violence victimization has been well documented in the literature. That is, people who experience one type of violence victimization (e.g., bullying) are at higher risk for other types of violence victimization (e.g., dating violence) (A. Brown et al., 2009; Miller et al., 2013). In adolescence, this behavior can be better understood from a developmental perspective. Pepler et al. (2006) conducted a longitudinal study of multiple forms of violence (e.g., bullying, dating violence, sexual harassment) in adolescence. This study found earlier reports of bullying behavior were associated with emergence of sexual harassment and dating violence in later adolescence. The emergence of dating violence and sexual harassment coincided with pubertal development (i.e., when sexuality becomes increasingly important) among these participants. The authors also speculated that children who bully use power and control to

navigate relationships, and that behavior generalizes to other relationships (i.e., dating partners) during adolescence. These findings highlight the need to conduct more research on dating violence among people with disabilities.

Findings from this study lend support to viewing protection from bullying victimization in the context of the social ecological model (Bronfenbrenner, 1979). The social ecological model depicts the multiple levels of influence on bullying victimization. While protective factors at the individual level (i.e., emotional competence, self-efficacy) of the social ecological model were not significantly related to bullying victimization, higher levels of protection at the family, peer, and school support protected students from being victims.

Results from the student survey and in-depth interviews supported the importance of the family in protecting from bullying and in coping with bullying. In Phase 1, higher levels of family support were associated with lower levels of bullying victimization. In the qualitative results of Phase 1 and Phase 2, several forms of family support were generated: parents' role in encouraging advocacy and siblings at school. Research indicates that parental support can protect students from bullying, and can buffer against the negative effects of victimization (Connors-Burrow, Johnson, Whiteside-Mansell, McKelvey, & Gargus, 2009). Several students in this study reported that because they had the support of their family, they were better able to advocate for themselves when victimized. Like Becca said, "having people not necessarily stick up for you but stand by your side made it a lot easier to combat bullying or ignore it than doing it by yourself." Participants who had more family support were also better able to advocate for their disability-related needs. For Buddy, getting support for his ADHD allowed him to

become successful at school, which increased his confidence and made forming and maintaining friendships easier. Previous research indicates that the quality of the parent-child relationship influences children's social, emotional, and school functioning (Murray, 2006).

Participants also reported support from siblings. Having an older sibling or relative at the same school was seen as an advantage and protected participants from bullying victimization. Indeed, this concept is supported in the literature on sibling relationships among children with disabilities (Tsao, Davenport, & Schmiede, 2012). Siblings who are more socially skilled can facilitate interactions among the sibling with a disability and peers. These siblings play an enormous role in the lives of children with disabilities, serving as a teacher, caregiver, a model for appropriate behavior in social situations, and someone with whom the child can confide.

Higher levels of peer support also resulted in lower levels of bullying victimization. After analysis of the interviews in Phase 2, information about *how* peers were protective became evident. For example, some participants in Phase 2 reported support from peers regarding their disability. Becca made an effort to educate her peers about Type 1 Diabetes and as a result, her friends were more supportive when she experienced diabetes-related complications. They also stood up for her when other students accused her of "faking low blood sugar" to get out of class.

While some participants like Anna and Becca reported experiencing support from peers when they provided education about their disability, others experienced the opposite reaction. When Ashley disclosed her Bipolar Disorder and related suicide attempt to her friends, she was ostracized and alienated from her friend group. Consistent

with previous research, participants with psychological or behavioral disabilities reported lower levels of peer acceptance than participants with medical disabilities (e.g., Type 1 Diabetes, cancer) (Sentenac et al., 2011; Swearer et al., 2012).

Another way in which participants gained support from peers was by associating with others who had a disability. Anna and Becca reported that peer relationships formed at summer camp were particularly influential for them. Both women described attending camp for children with Type 1 Diabetes as a turning point. They were able to meet other children with the same diagnosis, learn how to manage the diseases from peers, and to feel a part of a group and not like “the weird girl with diabetes.” Anna and Becca both described feeling less alienated from peers as a result of attending camp, because they gained a large support network from other campers. This finding lends support the literature indicating that association with like-minded peers, or those with whom the child has something in common, can reduce peer rejection (Farmer et al., 2012).

One unexpected finding that emerged from both Phase 1 and Phase 2 data was many participants felt victimized by teachers/school staff. Participants reported difficulty getting the needed accommodations at school, having to argue with administration to get services for which they were legally entitled under their 504 plan. Others, such as Lindsay, experienced relational aggression (rumor spreading, gossip) from teachers and coaches when a routine injury (i.e., ACL tear from basketball) evolved into an invisible disability (i.e., Chronic Regional Pain Syndrome). This victimization from adults in school settings has not been studied as widely as peer violence.

Research indicates that disability-related support from adults at school can have a profound influence on the physical and mental well being of children with disabilities. In

a study of middle school students with Type 1 Diabetes, those who attended a school in which school personnel received training on Type 1 Diabetes had better diabetes control (Wagner, Heapy, James, & Abbott, 2006). Students whose classmates received training on diabetes reported higher quality of life scores than students with untrained classmates.

Several participants experienced protection from bullying victimization based on the type of school they attended. Two of the Phase 2 participants, Ashley and Tyra, attended International Baccalaureate Programs, where they reported greater support from teachers. Ashley said she thought adults at the school were more understanding of “students who are different.”

Support for the concept of covitality was partially found in the present study. The main idea from the concept of covitality is that a combination of protective factors can be more influential than any single protective factor alone (Furlong et al., 2013). Since I did not use all of the measures from the Social and Emotional Health Scale, an exact covitaliy index was not calculated. However, analysis of the combined external protective factors (external protective factor index) revealed the more external protective factors participants reported, the lower their mean levels of bullying victimization. The internal protective factor index was not significantly related to level of bullying victimization. The present study is the first to apply the Social and Emotional Health Scale and the concept of covitality to the study of bullying victimization.

5.1 Limitations

This study has several limitations. The study was retrospective, so recall bias may have influenced the results. However, some research indicates that recall of bullying victimization is reliable. For example, in one study, 23 year old participants were able to

accurately recall bullying victimization in 9th grade (Olweus, 1993). The authors verified the participants' recollections with parent and teacher reports, and the two were highly correlated.

The gender distribution of the sample was unbalanced. Most of the respondents were female (78%) so more information on bullying among male students is needed. The study population was composed of students at a selective public university. Of students diagnosed with a disability during their K-12 education, approximately one-third enrolled in a postsecondary educational institution (IDEA, 2010). Since the sample for the present study was functioning well enough to gain admittance into a selective university, they are more likely to have more protective factors than students with disabilities who did not attend college. Furthermore, the present sample was selected from students who were registered with the Disability Resource Center. In their meta-analysis of help-seeking behaviors among postsecondary students, Trammel and Hathaway (2007) found that only 40% of students who received disability accommodations in high school did so at the postsecondary level. Therefore, students enrolled at the university but were not registered at the Disability Resource Center did not have a chance to participate in this study.

Results of this study indicated that internal protective factors (emotional competence, empathy, behavioral self-control, and self-efficacy) were not associated with levels of bullying victimization. This suggests possible lack of sensitivity of the internal protective factor measure used in the present study. It is also possible that different disabilities experience protection in different ways. For example, several participants with psychological disorders reported facing stigma and having social difficulties with peers as a result of their disability. Finally, the inclusion of a comparison group of

students without disabilities would have strengthened the results. Finally, students who were victims of bullying may have been more likely to complete the survey, in spite of the instructions stating that victimization was not a requirement for participation.

5.2 Conclusions

This study serves as one of the first to examine factors that protected children with disabilities from bullying victimization at each level of the social ecological model. In both the survey and individual interviews, participants reported that family, peer, and school support played a major role in coping with and avoiding bullying victimization. This study is also one of the first studies to use the new CDC definition of bullying victimization (Gladden et al., 2014). Based, on this definition, participants reported experiencing frequent and severe bullying victimization.

The long-term goal of this research is to design an intervention that incorporates the influential protective factors from this study. Based on these results, interventions targeting students with disabilities should incorporate a disability education component for family, peers and school officials. These education components could reduce stigma associated with the disability and help give people a language with which they can communicate with the students who have disabilities. This study clearly demonstrated a need for more research into bullying victimization among this population. Every child should feel safe in school, especially those with disabilities who are among the most vulnerable.

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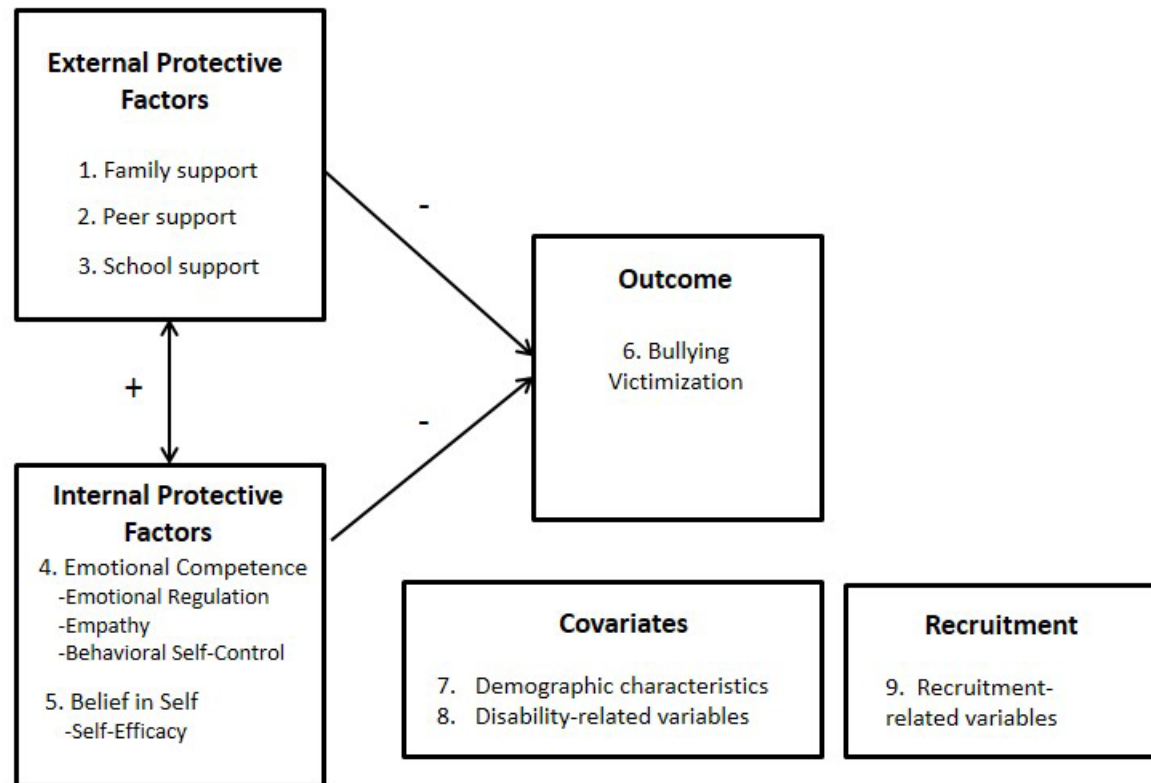
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APPENDIX A: CONCEPTUAL MODEL AND SCALES



Construct	Measure	Description of Measure	Internal Consistency	Reference	
External Protective Factors					
1.	Family Support	Social and Emotional Health Survey	4 items measuring positive relationships with adults at home.	0.86	Constantine & Bernard, 2001
2.	Peer Support	Social and Emotional Health Survey	4 items measuring social health among 8-17 year olds	0.86	Adapted from DeWalt et al., 2013
3.	School Support	Social and Emotional Health Survey	4 items measuring support from adults at school	0.86	Adapted from Furlong et al., 2013.
Internal Protective Factors					
4.	Emotional Competence	Emotional Competence subscale from the Social and Emotional Health Survey	9 items measuring emotional regulation, empathy, and behavioral self-control.	0.82	Adapted from Furlong et al., 2013.
5.	Belief in Self	Belief in Self subscale from the Social and Emotional Health Survey (college edition)	6 items measuring self-efficacy	0.90	Adapted from Furlong et al., 2013.
Bullying Victimization					
6.	Bullying Victimization	Retrospective Bullying Questionnaire	8 items measuring physical, verbal, and relational bullying victimization. 2 items measuring disability-related victimization and time period of victimization.	0.88	Adapted from Schafer, Korn, Smith, Hunter, Mora-Merchant, Singer, et al., 2004
Demographics					

	Construct	Measure	Description of Measure	Internal Consistency	Reference
7.	General Demographics	General demographic items from the YRBSS	7 items assessing gender, age, race/ethnicity, school type (rural vs urban), geographic location, and job type	N/A	Adapted from CDC, 2013
8.	Disability-specific	General demographic items assessing disability status	2 items assessing diagnosed disability and age of diagnosis	N/A	Developed for this study
Recruitment					
9.	Recruitment	Developed for this study	1 item assessing how the participant heard about the study	N/A	Developed for this study

* Cronbach's Alpha for entire questionnaire of 32 items was .92

External Protective Factors

Response categories: *Not at all true* (1), *A little true* (2), *Pretty much true* (3), *Very much true* (4)

Prompt: Select the answer that best describes how you feel about each statement, thinking about middle and high school:

1. Family Support

Title: Social Emotional Health Survey: items 1 to 3; designed for this study: item 4

1. My family members really help and support one another.
2. There is a feeling of togetherness in my family.
3. My family really gets along well with each other.
4. My parents or guardians had a good understanding of my disability.

2. Peer Support

Title: Social Emotional Health Survey: items 1 to 3; designed for this study: item 4

1. I had a friend my age who really cared about me.
2. I had a friend my age who talked with me about my problems.
3. I had a friend my age who helped me when I was having a hard time.
4. My friends had a good understanding of my disability.

3. School Support

Title: Social and Emotional Health Survey: items 1 to 3; designed for this study: item 4

1. There was usually a teacher or other adult who always wanted me to do my best.
2. There was usually a teacher or other adult who listened to me when I had something to say.
3. There was usually a teacher or other adult who believed that I would be a success.
4. The services that my school provided for my disability helped me to succeed.

Internal Protective Factors

Stem: Select the answer that best describes how true you feel that this statement is about you personally

Response categories: *Not at all true* (1), *A little true* (2), *Pretty much true* (3), *Very much true* (4)

4. Emotional Competence

Title: Emotional subscale from the Social and Emotional Health Survey

1. I accept responsibility for my actions.
2. When I make a mistake I admit it.
3. I can deal with being told no.
4. I feel bad when someone gets their feelings hurt.
5. I try to understand what other people go through.
6. I try to understand how other people feel and think.
7. I can wait for what I want.
8. I don't bother others when they are busy.
9. I think before I act.

5. Belief in Self

Title: Belief in Self – self efficacy subscale from the Social and Emotional Health Survey

1. I trust my own ability to overcome challenges that I face in my life.
2. The majority of the time, I feel capable of overcoming obstacles.
3. If I fail at a goal, I find alternative ways to achieve it.
4. I will be able to achieve most of the goals that I have set for myself.
5. I will be able to successfully overcome many challenges.
6. I am confident that I can perform effectively on many different tasks.

Bullying Victimization

6. Bullying Victimization

Title: Retrospective Bullying Questionnaire

Response categories: Never (0), Rarely (1), Sometimes (2), Frequently (3), Constantly (4)

Prompt: How frequently did you experience any unwanted aggressive behavior in middle or high school from a classmate or peer in your school (not a date or a sibling)?

1. Being hit, punched, or shoved
2. Stolen from
3. Being called bad names
4. Being threatened
5. Having lies or bad rumors told about you behind your back
6. Being deliberately excluded from social groups
7. Being called bad names, being threatened, or having lies or bad rumors told about you through an electronic source (e.g., email, chat rooms, instant messaging, websites, or texting)
8. Other problematic behavior (please specify)

Disability-related behaviors: Do you think the bullying you experienced was related to your disability?

Response categories: *(Yes, No)*

If yes, please explain *(open ended)*

Middle/High School. During what time of your life did this bullying occur?

Response categories: *(They did not happen, Mostly in middle school, mostly in high school, both middle and high school, other (please specify))*

Open-Ended Questions

1. If you did experience bullying in middle school or high school, what helped you to cope? Describe what happened.
2. If you did not experience bullying in middle school or high school, what protected you from that bullying? Describe what happened.

Demographic Variables

Demographic and Recruitment Variables

7a. Demographic Characteristics

1. Are you? (*male/female/trans*)
2. Age? (open response)
3. Are you Hispanic or Latino? (*yes/no*)
4. What is your race? [Mark all that apply] (American Indian or Alaska Native, Asian Indian, Other Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Some other race: Please specify)
5. What type of school did you attend? (public, private religious, private independent, homeschool, I didn't attend school, GED program)
6. How would you describe the area where you live? (Large city (population over 250,000), Mid-size city (population under 250,000), suburb of a large city, suburb of a mid-size city, Town (not a major metropolitan area), Rural area)
7. How would you characterize your present employment status? (Full-time; Part-time; Not employed)

7b. Disability-related Variables

1. What is your diagnosed disability? (Learning disabilities, attention-deficit hyperactivity disorder, pervasive developmental disorders, acquired brain injuries, psychological disorders, sensory disorders, mobility disorders, systemic disorders, and other disorders)
2. At what age were you diagnosed with this condition?

8. Recruitment

Developed for this survey

Introduction: We are trying to understand what makes people decide to participate in one of our research studies. The next question asks about your decision to participate.

1. How did you hear about this study? (Check all that apply: UGA DRC listserv, UGA DRC staff member, University System of Georgia DSP listserv, University System Georgia DSP staff member, social media, other (please specify).

APPENDIX B: RECRUITMENT MATERIALS

Listserves:

Let your voice be heard! If you have a diagnosed disability and are between 18 and 24 years old, Caroline McNicholas (University of Georgia) invites you to participate in a research study titled “*Victimized for Being Different: Young Adults’ Recollections of Bullying Victimization During Middle and High School.*” The goal of the study is to understand what types of bullying youth with disabilities experience and whether certain factors may protect these youth from bullying.

What will I do? You will complete a survey that takes about 15-20 minutes. Your participation is voluntary; you can stop or skip questions at any time. Your participation is anonymous; no names or any identifying information is asked.

Ready to take the survey? You can take the survey online at: <Will link to consent form>

Your participation is really important. The information that you give will be used to develop programs that can help youth like you and those around them. THANK YOU FOR PARTICIPATING!

APPENDIX C: PHASE 1 SURVEY CONSENT

WHAT FACTORS PROTECT AGAINST BULLYING?

Children with disabilities suffer an inordinate amount of bullying in middle and high school. The goal of this study is to identify factors that may protect individuals with physical, educational, social or emotional disabilities from bullying victimization. The information will be used to develop bullying interventions for children with disabilities. If you are between **18-24 years of age** and have a **diagnosed disability**, we invited you to participate in the research study: “*Victimized for Being Different: Young Adults’ Recollection of Victimization During Middle and High School.*” You **do not** have to be a victim of bullying to participate in this study.

If you decide to participate in this study:

- You will complete a survey (about 15-20 minutes). The survey contains questions about your demographic characteristics; your relationships with family, friends, and school personnel during middle and high school; type of disability; and any bullying you may have experienced. You will not need to disclose your name, date of birth, or citizenship status.
- Foreseeable risks are minimal. Some people may experience discomfort associated with describing bullying experiences. Remember that you can refuse to participate, skip any questions, or withdraw from the study at any time. Your participation is voluntary. Because you are completing the survey online, there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, this risk is minimal as no personally identifiable information is requested.
- As a token of appreciation for your participation, you have the option to enter a drawing to win one of five \$50 gift cards. You do not need to participate in the study to enter the drawing.

At the end of the survey, one question will ask whether you are willing to be interviewed about your experiences in middle and high school. If you are willing, select “yes.” A new page will ask for an email address to contact you. Your email address and your survey will not be linked. This study is conducted by Caroline McNicholas, MA (706-542-3408; cmcnich@uga.edu) under the direction of Pamela Orpinas, PhD, (706-542-4372; porpinas@uga.edu) at the Department of Health Promotion and Behavior, University of Georgia. Please contact them if you have any questions. Additional questions or problems regarding your rights as a research participant should be addressed to: The Chairperson, Institutional Review Board, University of Georgia, 629 Boyd Graduate Studies Research Center, Athens, Georgia 30602; Telephone (706) 542-3199; Email address: IRB@uga.edu.

I understand that by clicking the SUBMIT button, I acknowledge that:

- I am **between the ages of 18-24.**

- I have a **disability** (i.e., any physical or mental impairment that substantially limits one or more major life activities) **that has been diagnosed by a medical professional** (e.g., physician, psychologist, psychiatrist).
- I have read the above information, and I agree to participate in this survey.
- I can print a copy of this consent form.

SUBMIT (You will start the survey)

DO NOT SUBMIT (This will end the survey)

APPENDIX D: PHASE 2 INTERVIEW CONSENT
WHAT FACTORS PROTECT AGAINST BULLYING?

Children with disabilities suffer an inordinate amount of bullying in middle and high school. The goal of this study is to identify factors that may protect individuals with disabilities from bullying victimization. The information will be used to develop interventions for children with disabilities.

If you are between **18-24 years of age** and have a **diagnosed disability**, we invited you to participate in the research study: “*Victimized for Being Different: Young Adults’ Recollection of Victimization During Middle and High School.*” You **do not** have to be a victim of bullying to participate in this study.

If you decide to participate in this study:

- You will be asked to complete a 1-hour interview. The interview will be about your experiences with bullying and any factors that lessened or increased the bullying. You will not need to disclose your name, date of birth, or citizenship status.
- At the beginning of the interview, you will choose a pseudonym so that your real name does not appear in the transcript of the interview. There will be no link between your name and your pseudonym. Only the research team will have access to the information you provide, and none of the information will be shared unless required by law.
- With your permission, the interview will be audio recorded. The audiotapes will be destroyed after analyzing the data. If you so choose, you can meet with Caroline to review the completed transcript and correct or remove any information.
- Foreseeable risks are minimal. Some people may experience discomfort associated with describing bullying experiences. Your participation is voluntary. Remember that you can refuse to participate, skip any questions, withdraw from the study at any time, or request that all the interview data be destroyed.
- As a token of appreciation, participants will receive a \$25 Target gift card for participating in the interview.

This study is conducted by Caroline McNicholas, MA (706-542-3408; cmcnich@uga.edu) under the direction of Pamela Orpinas, PhD, (706-542-4372; porpinas@uga.edu) at the Department of Health Promotion and Behavior, University of Georgia. Please contact them if you have any questions. Additional questions or problems regarding your rights as a research participant should be addressed to: The Chairperson, Institutional Review Board, University of Georgia, 629 Boyd Graduate Studies Research Center, Athens, Georgia 30602; Telephone (706) 542-3199; Email address: IRB@uga.edu.

I understand that by signing this form, I acknowledge that:

- I am **between the ages of 18-24**.
- I have a **disability** (i.e., any physical or mental impairment that substantially limits one or more major life activities) **that has been diagnosed by a medical professional** (e.g., physician, psychologist, psychiatrist).
- I have read the above information, and I agree to participate in this interview.
- I have received a copy of this consent form.

Participant signature _____ Date _____

Researcher signature _____ Date _____

APPENDIX E: PHASE 2 INTERVIEW GUIDE

Interviewer's introduction

Hi, my name is Caroline McNicholas; I am a doctoral student at UGA. As part of my research I am interested in learning what protects people with disability from peer aggression during middle and high school. Even if you didn't experience aggression, I am interested in your story to understand what protected you. If some of these topics become difficult to talk about, we can stop the interview at any time, or move on to a different question.

Background questions

- I would like to start with your disability status. What is your diagnosis?
 - Tell me what that means?
 - Tell me about what led to your diagnosis?
- When were you diagnosed with XYZ?
- How do you experience disability XYZ?
 - Prompt – what difficulties do you experience? Tell me what happened.
- What was it like having disability XYZ in your family?
- What was it like having this disability at school?
- Did you have friends at school with disabilities?
- Did you witness any of your friends getting picked on?

Peer Aggression Questions

Did any kids treat you in ways that made you uncomfortable? Tell me about it.

- Prompt. For example, did any other kids -
 - Hit, punch, or shove you?
 - Steal from you?
 - Call you bad names?
 - Threaten you?
 - Tell lies or bad rumors about you behind your back?
 - Deliberately exclude you from a social group?
 - Make threats, call you mean names, or spread bad rumors about you behind your back online? (in a text message, on social media sites like Facebook or Instagram, or in a chat program)
- What was that like for you? (during, after)
- If any of your friends witnessed what happened, tell me about how they reacted.
- Tell me about how the adults in the school (teachers, principal) reacted.
- Did you report what happened to any adults? What happened?
- Did you tell your family? Tell me about how they reacted.
- How do you think your disability may have been a part of this experience, if at all?

Closing Remarks

Thank you so much for doing this interview. If I have any more questions, would it be alright to contact you? Please don't hesitate to contact me if you have any questions.